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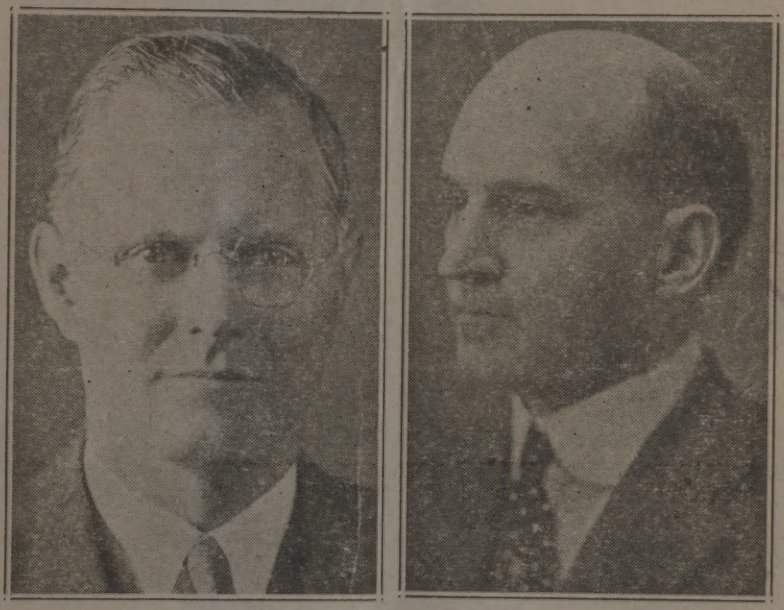

The good-will get-together meeting at Ole Miss was chiefly to do honor to Dr. J. C. Culley and Dean P. L. Mull. They have been big factors in saving the medical department at our beloved University. Great benefit might be derived from making this meeting an annual affair.

The two year Medical course at Ole Miss has stood the test of time, the test of high grade scholarship, and the test of practical application of modern medicine. Its thoroughness has challenged the admiration of the rich and the most cultured, its reasonable fees has made it possible for the poor who possessed a professional mind in the rough, a medical soul and a missionary heart to realize a pounding ambition. Our hearts swell with gratitude and with pride when we think of the service this school has rendered. We believe we speak for the medical profession of the state. We pledge our loyalty to its banner. It is our will that this school may have life and may have it more abundantly. This school and the medical profession should be of mutual benefit one to the other. We need the latest teachings that it may bring. It needs the benefit of our experience in practical application.

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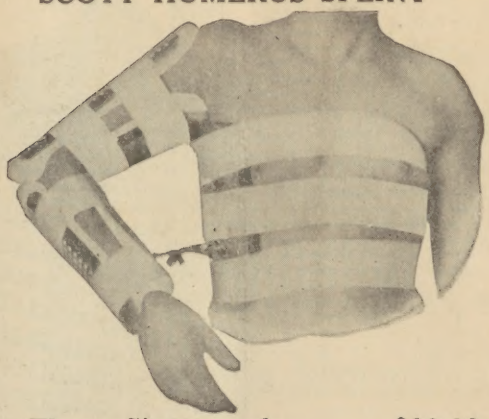

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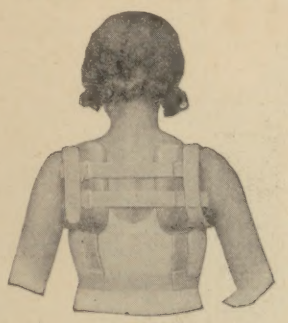

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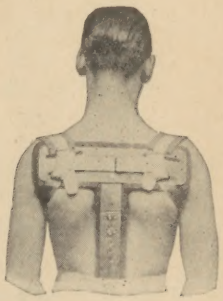

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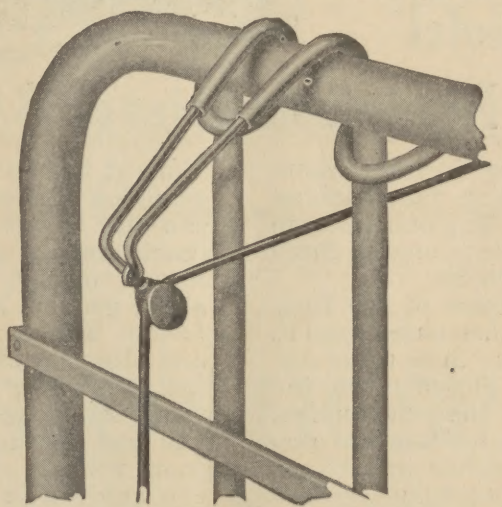

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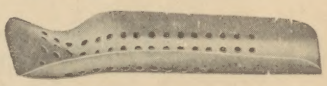

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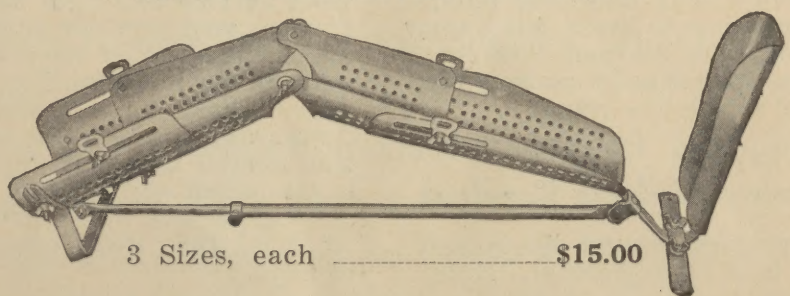

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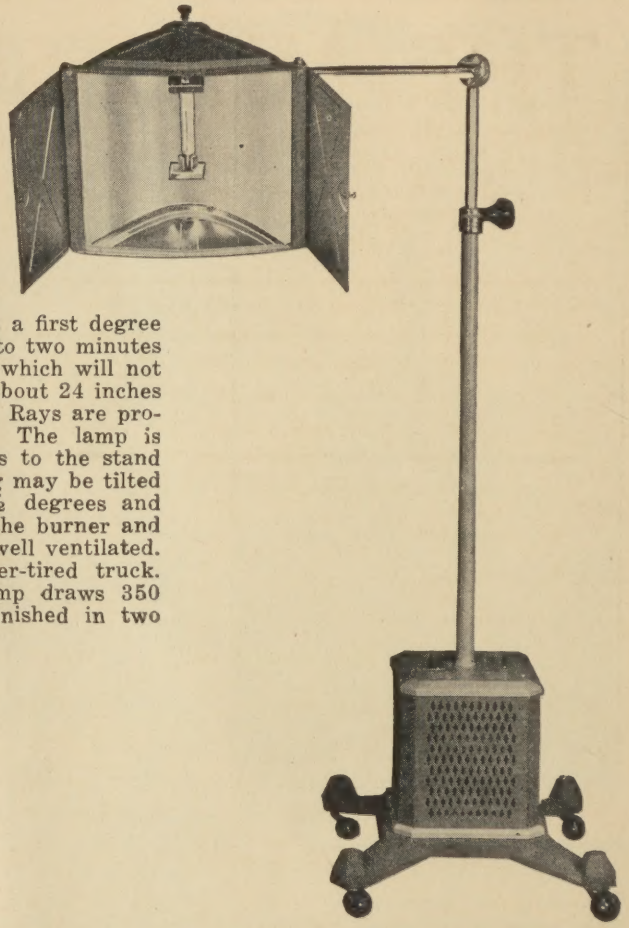
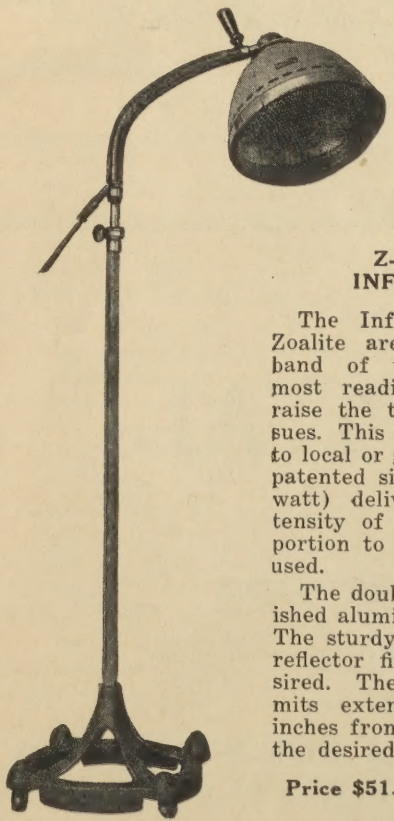


The new Burdick Quartz Ultra-violet Lamp gives a first degree erythema on the average untreated skin in from one to two minutes at 30 inch skin distance. The reflector is chromium which will not tarnish. The concentration of the rays over an area about 24 inches wide at 30 inch skin distance increases the intensity. Rays are projected and reflected evenly. Burner starts easily. The lamp is handily portable. Has extension arm at right angles to the stand making irradiation over a bed convenient. The casing may be tilted at three different angles—(a) vertical; (b) at 22½ degrees and (c) at 45 degrees. The casing has doors to protect the burner and the patient while the lamp is building up. Casing is well ventilated. Mounted on control cabinet as a base, with rubber-tired truck. Operates from any ordinary appliance circuit. Lamp draws 350 watts—about half as much as an electric iron. Finished in two tones of restful gray lacquer.

Price $175.00 F. O. B., Memphis.



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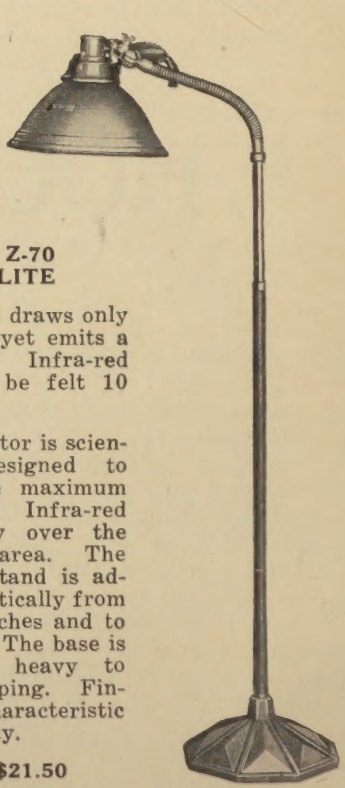
The double-wall reflector of polished aluminum is fully ventilated. The sturdy flexible arm holds the reflector firmly at any angle desired. The telescopic upright permits extension from 40 to 72 inches from the floor and locks at the desired height.

Price $51.50 F. O. B., Memphis.



THE Z-70 ZOALITE

This lamp draws only 220 watts, yet emits a volume of Infra-red which can be felt 10 feet away.

The reflector is scientifically designed to project the maximum amount of Infra-red rays evenly over the treatment area. The telescopic stand is adjustable vertically from 41 to 61 inches and to any angle. The base is sufficiently heavy to prevent tipping. Finished in characteristic Burdick gray.

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THE MISSISSIPPI DOCTOR

OFFICIAL ORGAN OF THE NORTHEAST MISSISSIPPI 13-COUNTY MEDICAL SOCIETY
—AND—
NORTH MISSISSIPPI 6-COUNTY MEDICAL SOCIETY

W. H. ANDERSON, M. D., Editor and Manager

Entered as second-class matter, January 18, 1926, at the post-office at Booneville, Miss., under the Act of March 3, 1879.

Heretofore you have been warned to keep away from the stock exchange, but this year you have been driven to it. You have got to swap your practice for stock or go down.

Medical knowledge that was one time entirely in the hands of the specialist is now common knowledge and can not be charged for as before.

Play the exchange and save yourself economically.

It is not at all practical to think of a four year medical course at Ole Miss, nor would it be if the school was located in Jackson. The two year course is just what we need and what we can have.

We were very sorry that Dr. E. C. Ellett was unable to attend the meeting at Ole Miss.

There is no one thing common or of minor importance in the practice of medicine.

You will note that this issue of The Mississippi Doctor carries some unusually fine papers. This journal selects many of its papers. It brings subjects to you that you need to know about and by men who are amply able to give you the best that is known in this field. We are very greatful to Drs. Hill, Moore, and Rischener for their papers in this issue.

The Mississippi State Medical will meet in Jackson again next year. Dr. Will J. Mayo is expected on the surgical section.

Medical schools need to put in a special course for the general practitioner who must to a certain degree become a specialist.

Dr. Bethea's symposium on chest examinations before the "good will" meeting at Ole Miss was unique, practical, un-canny and calculated to be of great value in accurate of diagnosis of chest conditions.

The Editor of The Mississippi Doctor appreciates very much an invitation to attend the annual meeting of the Walnut Log Medical Society up at Union City on Nov. 13 and 14 of November. We are very sorry we will be unable to attend. This is a big affair the boys have up there. They have a fine medical program and then duck hunting et al. We just kinder dare them to invite us again.

Our next meeting of The North East Mississippi 13 County Medical Society will be held in Tupelo in December. We are expecting one of the best we have had for a long while.

A big part of the current medical education can and should be brought to the practitioner right at home.

Down at the Southern Medical you may have a chance to see and hear the great and profound Dr. Rudolph Matas. For years past and years to come the spirit of Tulane Medical School was and will be the spirit of this great medical philosopher. In the beginning he was born with a master mind. He had unusual opportunities by his affiliation with this great school. No other living man in our opinion possesses so much medical knowledge. He loves medical truths and by passing them on unselfishly, he seems to have been given many portions. In every field of knowledge he is a specialist. His brain is big and of the finest fiber. He has a medical soul that is magnanimous. His heart overflows with kindness and with sympathy for his patients. It will be a great treat to see him and to set at his feet and listen to his wisdom if only for one hour.

Take a little time to see Tulane while in New Orleans. It is a great school. Dean Bass is a man of vision. He is the essence of thoroughness in any undertaking. He is the outstanding leader in practicalizing modern medicine.

The North East Mississippi Medical Society can point to the President of the Southern Medical Association with pride and admiration. He is one of our own faithful and devoted members. He will do honor to this great medical association as its president.

If the profession carries modern medicine to the masses at a reasonable cost we need not fear State medicine.

The way to keep away from state medicine is for the profession to give such good service that the people will have no desire for it. This can be done by means of the well equipped clinic and the well equipped hospital in the small town out in the midst of the masses. Don't forget this.

Everything else being equal put up at the hotel when in New Orleans or Jackson or Memphis or any where else that advertises in The Mississippi Doctor. It will not cost you any more and it will help to finance the journal. Thank you.

Our November issue is going out just about three thousand strong. Who said Mississippi could not put out a medical journal?

If you want to read a journal that publishes good papers all the time and discusses the practical medical problems of today subscribe for The Mississippi Doctor.....For a single copy, one fifty for one year, in clubs of five, one dollar per year.

The good will get together meeting at Ole Miss in honor of Dean P. L. Mull and the two year medical school was a big success. It was good to the last act. In attendance it ranked well with the average state meeting. The scientific papers were good. Our welcome by Chancellor Powers was most cordial. The earnest blessings invoked by Mr. Guest were most fervent. The songs by Mrs. Martin were full of thrill and inspiration. The response to the welcome address by president-elect Acker was pointed and well said. The scientific symposiums by Drs. Livermore, Bethea, Street, and Rischener were the last word of reliable information on the subject. Dean Hyman of the University Medical School of Tennessee, brought an inspiring message of faith and good will. Dean Mull spoke touchingly from an earnest, a faithful, and an appreciative heart. Dr. Underword read encouragingly of the progress of medicine and quieted the fears of many on the matter of state medicine. State President Culley paid a high and a deserved tribute to the faithful work of Dean Mull, Dr. B. S. Guyton, and Dean Hyman et al for the medical department at Ole Miss in time of need. Yes, it was a nice big day. Surely it indicated to Dean Mull that the medical profession of the entire northern half of Mississippi appreciates his efforts, his faithful and untiring services for this school. Surely he must now know that the profession of the state is behind the medical department. It intends for this two year school to live and go forward.

The two year medical school at Ole Miss should live and should continue to function. We do not think we should consider a four year medical school, but the two year course has stood the test of time, the test of examination, and the test of practical application of modern medicine. Its thorough course challenges the admiration of the rich and the most highly cultured and its moderate fees make it possible for the young man of moderate means, but who has in reality a professional mind, a medical soul and a missionary heart, to come and to drink from the fountain of the latest and the purest medical knowledge. The two year medical school at Ole Miss hath wrought well. Our hearts swell with pride at her past record. We are bouyant with hope of her continued service. We need the teachings in physiology, chemistry, and bacteriology that it may bring to us. We trust that the medical profession shall determine that from this day on the medical school at Ole Miss shall have the benefit of practical application that we may be able to give and the yearly handshake of cordiality and good will that we may be able to bring to the Dean and to the student body. The gates of the spoils system in politics must not prevail against this school. Here Dean Mull, is our hand of good will, our heart of appreciation, and our blessings of hope and good cheer.

The Southern Medical Association meets in New Orleans on Nov. 18, 19, and 20. Dr. Felix J. Underwood, our own fellow member, our own efficient public health administrator, is

president. We should attend this meeting for our own good, our own professional edification, and also to show our appreciation to the Association for bestowing this, its greatest honor on one of our number. We have been reliably informed that an unusually good program has been arranged for this meeting And in addition you will enjoy your stay in New Orleans. It is our greatest southern city perhaps when everything is considered. It is broadminded. It is cosmopolitan. It is rich in culture and refinement. It is most interesting for its past history. It is exuberant with future hope. New Orleans is charged with a medical atmosphere that will do the soul and the intellect of any practitioner a world of good. New Orleans is the home of the best medical school in the United States in our opinion. It has as its dean Dr. C. C. Bass, a native Mississippian, who knows how to apply modern medicine in a practical way, knows how to teach it so it can be applied. You can't afford to miss the Southern Medical Association.

We were muchly delighted to have Dr. R. M. Holder of Memphis down to the meeting at Ole Miss. He is one of the faithful and true. He stands steadfast and goes forward in the profession. He is a surgical philosopher and his heart overflows with human interest.

IN KENTUCKY

A young lady without much knowledge of literature was told that she should secure a book for her vacation trip. She asked a book dealer for a suggestion of what she might choose, and he recommended "The Kentucky Cardinal" by James Allen.

"No," said the young lady. "I do not believe I would care for such a book; I never was interested in ecclesiastical history."

"But you are mistaken about this book," said the bookseller, "this cardinal was a bird."

"Well that still doesn't interest me," said the young lady, "I do not care anything about his private life."—Clyde Kelly.

MUSIC HATH POWER

Young people seated in the parlor. They had the jazz orchestra habit. The cook in the kitchen dropped a pan full of dishes with a terrible crash. "Shall we dance?" asked the young man, politely.

WHERE HIS FAMILY CAME FROM

A party of tourists were discussing the Darwinian theory. One of them turning to the guide said, "And what, my friend, do you think of the matter?",

"Well, sir," said the guide, "You gentlemen may all have come from apes. It's not for me to contradict you. But, as for me, I can say that my folks came from Wales."—Rev. Anthony H. Evans.

Disabilities of the Spine

BY HENRY G. HILL, M.D.
Memphis, Tenn.

In attempting to discuss a subject of such magnitude it is impossible to do more than briefly outline a few of the most common lesions. Disabilities of the spine may result from trauma, disease or congenital defect. Its bony substance is subject to the same type injury and disease that might befall any of the skeletal system, and fortunately is just as capable of repair. Unfortunately however, many of these conditions are associated with damage to the cord, which when once destroyed makes no effort to regenerate.

TRAUMA—Perhaps the most frequent traumatic condition other than sprains and lacerations of muscles and ligaments is the compression fracture of the body of the vertebra. This

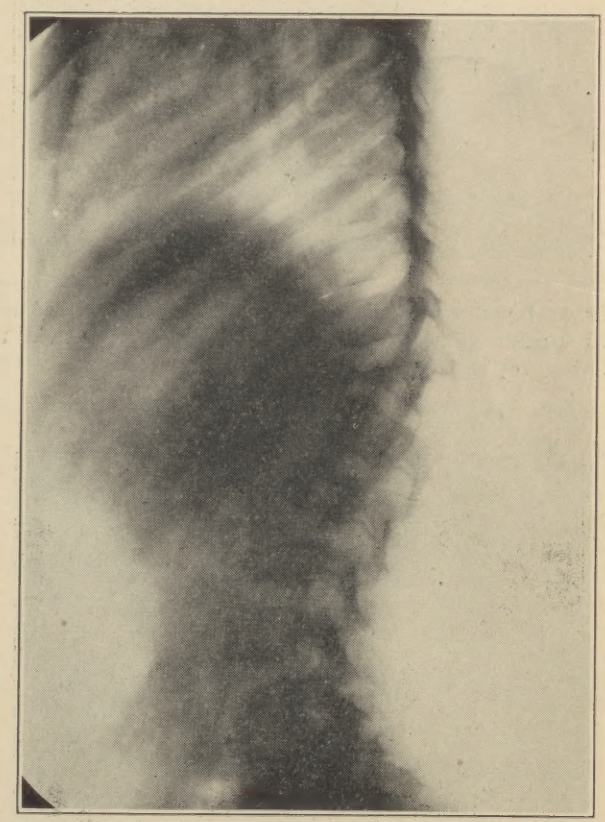

Fig. 1. Lateral X-ray view of compression fracture 11th dorsal vertebra.

may occur at any level, and usually results from indirect violence. Simple compression fractures of the cervical vertebrae are relatively rare, the most common location being in the lower dorsal and upper lumbar region. The symptoms vary widely depending upon its severity. Pain is constant and may be both local and referred. In severe cases with considerable destruction of the body a sharp angular kyphos is seen at the site of fracture. Involve-

ment of the cord is frequently associated with these injuries, and may result in any degree of paralysis.

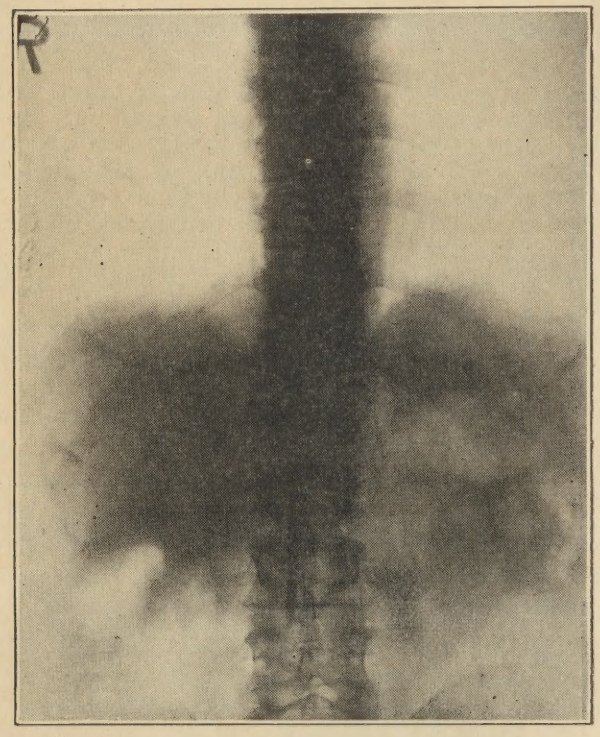

Fig. 2. Bone graft fusion 11th, 12th, dorsal. 1st, 2nd, and 3rd lumbar vertebrae for old compression fracture 1st lumbar vertebra (Kummel's disease).

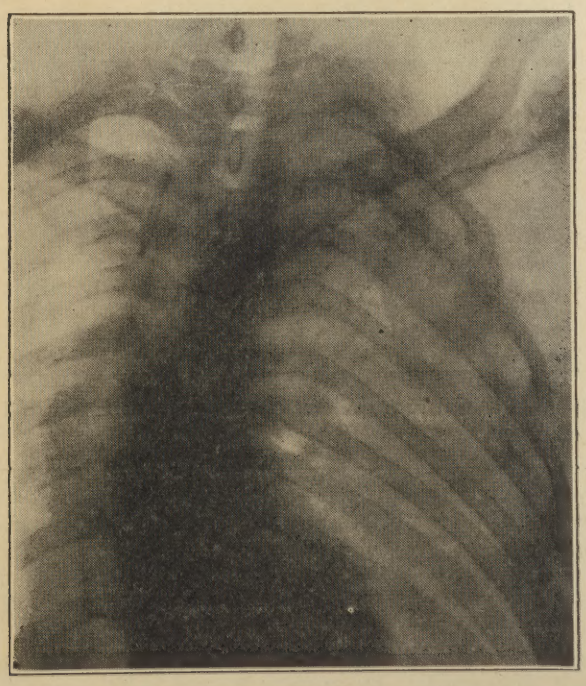

Fig. 3. Fracture dislocation of spine at level of 6th dorsal vertebra.

The X-ray examination is by far the most important aid to diagnosis. In some cases little is to be learned from the anterio-posterior view and a lateral exposure should be made routine in all X-ray examination of the spine. In the lateral view the body of the injured vertebra is found to be decreased in height, especially

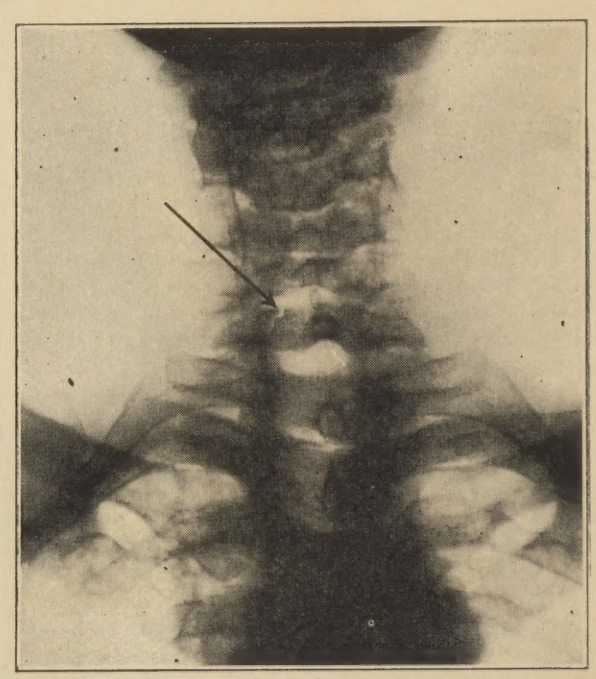

Fig. 4. Linea fracture body 7th cervical. Note arrow pointing to small nitch just to left of mid line.

at its anterior margin, so that it will present a wedge shaped appearance. There is an angulation of the spine at the site of fracture, and a decrease in the thickness of the inter-vertebral disc. A disturbance of the architecture of the injured vertebra is also seen in a well detailed picture.

The prognosis as to life does not depend upon the bony injury but upon associated conditions, especially lesions of the cord. Permanent paralysis will result from an acutal severance of the cord. Pressure from the bony fragments, oedema, and hemorrhage in the spinal canal may produce a paralysis that will disappear when the pressure is relieved. With no involvement of the cord the period of disability varies from six to twenty-four months. A permanent feeling of weakness frequently results when these injuries do not receive treatment.

Another type of fracture of the spine seen frequently in mechanics, football players, iron workers and trainsmen, usually a result of direct violence, such as a kick in the back or an injury sustained by falling on a small hard object, is a fracture of one or more of the transverse processes. Pain, tenderness and limitation of motion are the prominent symptoms and the fractured processes can be seen on the anterio-posterior X-ray plate. Such injuries are

sometimes very troublesome and are frequently associated with extensive soft tissue injury.

Traumatic dislocations of the vertebrae are accompanied by severe symptoms and are always serious injuries. The cord is always injured, the prognosis is poor, the patient often dies before the examination can be completed. A certain amount of permanent disability invariably results.

Fig. 5. Anterio-posterior view of advanced tuberculosis of spine involving several vertebrae mid-dorsal region.

Fig. 6. Tuberculous destruction of the 10th, and 11th dorsal vertebrae.

Fig. 7. Photograph of patient with tuberculosis of upper lumbar spine showing sharp angular kyphosis.

The lamina are also sometimes fractured with or without fracture of the body of a vertebra. Fractures of the sacrum are rather rare and usually unrecognized unless a well detailed X-ray picture is obtained.

Fractures of the coccyx occur more often and

Fig. 8. Advanced osteoarthritis of dorsal spine with complete bony ankylosis of all dorsal vertebrae.

may be detected by palpation and manipulation of the coccyx with a finger in the rectum. Here too, the X-ray examination confirms the diagnosis.

Gunshot wounds of the spine are not uncommon, and cord symptoms even though indicating that the missile has entered the canal does not always mean an irremediable cord lesion. The question of when to do a laminectomy in these cases as in dislocations and fractures is often a difficult problem and must be decided by the surgeon in charge. When the symptoms indicate an incomplete lesion of the cord operative interference should be done within the first

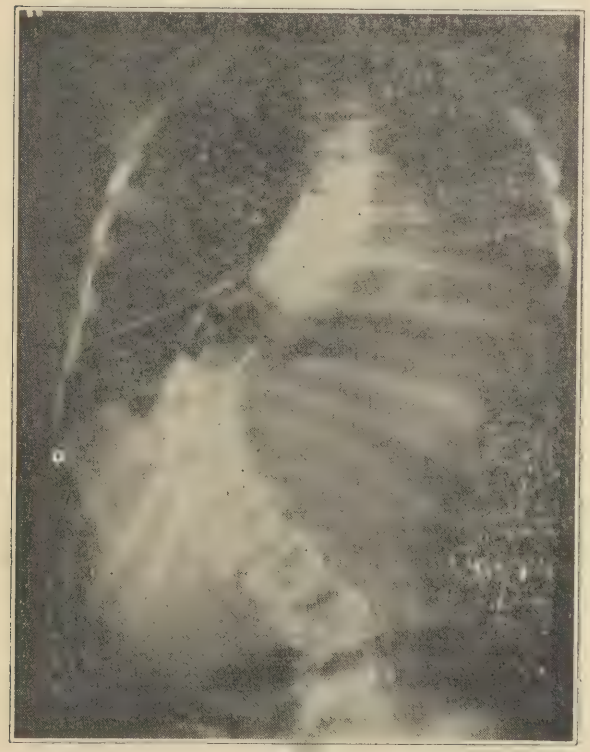

Fig. 9. Severe scoliosis following a neglected case of anterior poliomyelitis.

Fig. 10. Photograph of patient shown in Fig. 9.

Fig. 11. Anterio-posterior X-ray view of scoliosis after bone graft to 4th and 5th lumbar vertebrae and sacrum; and fusion of left sacro iliac joint.

Fig. 12. Photograph of patient after bone graft operation for correction of moderate paralytic scoliosis.

Fig. 13. Metastatic carcinoma destroying the body of 4th lumbar vertebra.

few days.

DISEASE—Tuberculosis of the spine or Pott's disease is a chronic destruction of the bodies of the vertebrae; it is seen at all ages but more common in children and may become acute at any state of the disease.

The etiology of tuberculosis of the spine does not differ from that of tuberculosis of any location; it is an infectious disease, the tubercle bacillus being the causative agent The predisposing cause may be both general and local. Unhygienic living conditions, improper food, lack of sunshine and fresh air and other conditions that would lower the vitality of the patient would render them more suceptible to the disease, while trauma to the vertebra lowers its resistance and offers a fertile field for development of the bacilli.

The process may begin either in the anterior or central portion of the body, most often there are several minute foci gradually enlarging un-

Fig. 14. Lateral X-ray view of lumbo-sacral spina-bifida.

Fig. 15. Photograph of patient with lumbo-sacral spina-bifida.

Fig. 16. Enlarged transverse process of 5th lumbar vertebra impinging upon wing of ilium.

til they coalesce, forming a cavity filled with tuberculous granulation enclosed by a cortical substance. Finally the vertebral bodies collapse under the pressure of the super-incumbent weight. The process is usually limited to one or two vertebrae but may extend up or down the spine including several. The inter vertebral discs though offering some resistance to the spread of the disease are quickly destroyed when the bone on either side of it is infected. The posterior portion of the vertebra is rarely involved.

Pain is an important symptom; it does not localize itself in the neighborhood of the disease, but is referred down the course of the nerves which lie in contact with the diseased vertebra. It is not always constant but is aggravated by jars or by sudden unguarded move-

Fig. 17. Photograph of patient wearing Taylor Spine Brace with collar attached. Spondylitis upper dorsal vertebrae.

Fig. 18. Photograph of patient with osteomyelitis of cervical spine, involving 2nd, 3rd, 4th, 5th and 6th vertebrae before treatment.

Fig. 19. Same as Fig. 18. Front view before treatment.

Fig. 20. Same as Fig 18 and Fig. 19. After treatment.

ments. In an effort to avoid these unguarded motions the muscles surrounding the diseased area of the spine are in a state of constant spasm. This is partly voluntary and partly involuntary but it always present and therefore an important symptom of Pott's disease. This spasm is indicated by a stiffness of the spine and an awkardness of practically all voluntary motions. The muscles relax when the patient sleeps allowing motion in the affected segment of the spine causing pain. This is responsible for the night cries so characteristic in children. Deformities appear as the destructive process progresses. This may be a sharp angular kyphos or a gradual rounded posterior protrusion of the spine, depending upon the number

of vertebrae involved. In certain locations other deformities are seen such as the so-called "pigeon chest" where the disease is located in the thoracic region, the attitude of wry-neck frequently associated with tuberculosis of the cervical spine, etc.

The X-ray examination is very important in confirming a diagnosis. Evidence of the disease may be seen in both the anterio-posterior and lateral views, but it can be detected much earlier in the lateral. Irregularity of the anterior edge of the vertebra is characteristic, later wedging of one or two bodies and disappearance of the inter-vertebral disc is seen.

The prognosis depends largely on the age of the patient and the severity of the deformity. In the typical hunch back the contents of the abdomen and chest are compressed, the blood vessels distorted, respiration is difficult and there is considerable hypertrophy of the heart. Most of these patients die in the early years of life. When the deformity is less severe the outlook is more favorable. The prognosis in children is better than in adults, although many cases of both classes recover sufficiently to live useful lives when the proper treatment is instituted.

Arthritis, or osteoarthritis, of the spine is a chronic inflammation affecting primarily the ligaments and the peri-osteal coverings of the spine. It is an ossifying peri-ostitis which binds the vertebrae firmly to one another. It is usually acute in onset, followed by a gradually increasing stiffness of the spine, it is associated

Fig 21. Front view after treatment.

Fig. 22. (Pen and Ink drawing by Mrs. Hill). Spinous processes have been removed down to laminae. Skin, fascia and muscles retracted.

Fig. 23. (Pen and Ink drawing by Mrs. Hill). Laminae are removed exposing cord and its covering.

Fig. 24. (Pen and Ink drawing by Mrs. Hill). Coverings of the cord are incised and suture is passed through dura and retracted to expose cord substance.

with pain, weakness, stiffness and frequently the spine is bent into a long kyphosis. Its progress is very gradual often extending over a period of years, many cases proceed to complete bony fusion of the spine, and since the pain is due to motion the patient becomes pain free when ankylosis has taken place.

Occasionally acute osteomyelitis of the spine is seen. The bodies of the vertebra are usually involved. The symptoms are similar to those of any acute infectious process. It is sudden in onset, associated with a marked elevation of temperature, general disability, and the appearance of being acutely ill. There is an increase in the cell count, and other evidence of sepsis is present. Locally the disease area is attended with a deep boring pain, and is tender to deep pressure.

The prognosis is always grave but the more localized and chronic form is far less dangerous. Occasionally an abscess may be the first sign of the disease.

Anterior poliomyelitis is a disease of the anterior portion of the spinal cord—it may be followed by a complete or partial paralysis of one or more groups of muscles in any location in the body. Should this paralysis affect the muscles on one side of the vertebral column leaving those on the opposite side unopposed, the strong group of muscles will continue to exert their force gradually pulling the vertebra away from the mid line producing sometimes a very crippling scoliosis.

Syphilis, malignancy, etc., may attack the spine, these conditions especially the former, sometimes so closely imitate other diseases that a diagnosis may be difficult, upon physical examination; however, other evidences of the disease will be found.

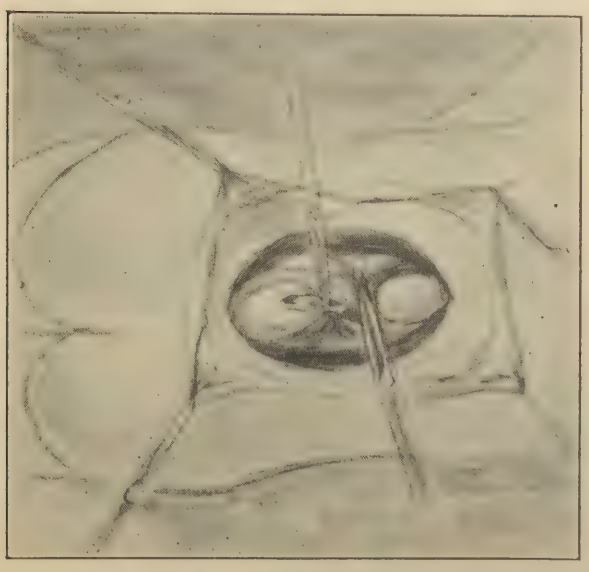

Fig. 25. (Pen and ink drawing by Mrs. Hill). Plastic operation for spina-bifida after sac has been removed.

CONGENITAL DEFECTS—Among the most distressing congenital defects of the spine is spina-bifida. In this condition the laminae or spine of one or more vertebrae are deficient, most frequently in the lumbo-sacral region allowing a protrusion of the contents of the spinal canal in the median line. In case the laminae are ununited but there is no protrusion the condition is called spina-bifida occulta. There are three distinct varieties of spina-bifida. First, the meningocele which is a simple protrusion of the arachnoid distended with fluid so as to form one continuous cavity; second, the meningomyelocele which contains cord substance in addition to the arachnoid, and third, the syringomyelocele, a protrusion of the cord. There is a great distension of the central canal, the sac wall being formed of the thinned cord and the spinal membranes.

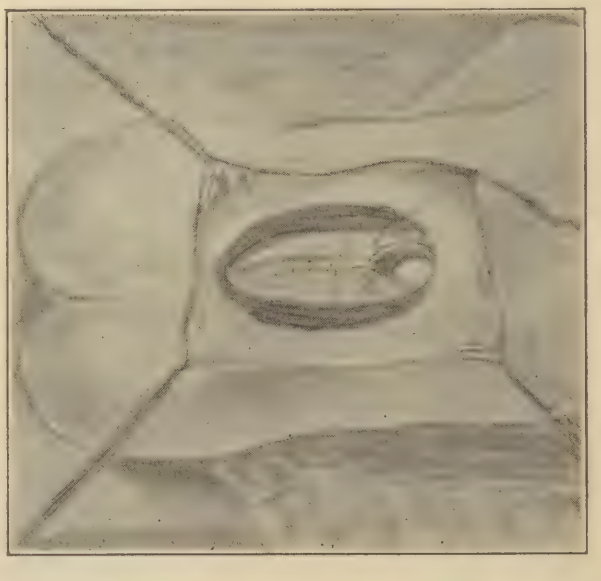

Fig. 26. (Pen and ink drawing by Mrs. Hill). Approximation of fascial flaps to meningeal defect.

A spina-bifida may vary in size from one to fifteen cms or more in diameter, it grows rapidly during the early weeks of life, it may be sessile or pedunculated. Upon pressure the tumor may diminish in size and increase the tension of the anterior fontanel.

Super-numerary vertebrae, cervical ribs, elongated transverse processes and numerous other defects are sometimes found on X-ray examination. Where their growth produces pressure on the surrounding tissue they may cause distressing symptoms, most often however, they are discovered on X-ray examination made for other purposes.

Congenital curvatures, as well as, ricketic changes are frequently discovered in the spine. When mild, such deformities usually go unnoticed unless for some reason the physician's attention is directed to a special examination of the spine.

Is the Operation of Prostatectomy to Become Obsolete?

BY THOMAS D. MOORE, M.D.
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Memphis, Tenn.

This startling question may well be asked in view of the progress made in recent years in the treatment of prostatic obstruction. Due to the ingenuity of Bottini, Freudenberg, Young, Braasch, Caulk, and others, the punch operation has been employed successfully for many years in those cases in which the obstruction was of the median lobe or median bar type. Until the present time, however, in instances of marked hypertrophy with large lateral lobe obstruction, nothing short of a prostatectomy, either perineal or suprapubic, has offered any real prospect of relief.

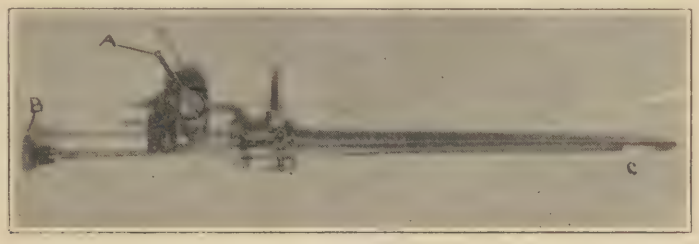

Fig. 1. The Stern-Davis Resectoscope. (A) Rack and pinion for operating loop electrode. (B) Observation telescope. (C) Fenestra which engages obstructing tissue.

In 1926 Stern devised the resectoscope, an instrument with which large lateral lobes could be removed, bit by bit, with a cutting current. In this instrument was incorporated a wire loop electrode which, by means of a rack and pinion was carried through the obstructing tissue with a backward and forward sliding motion. Each segment removed was cylindrical in shape, nearly an inch in length, and somewhat larger than the diameter of the cutting loop. Any number of such segments could be removed in as many tiers as was required to effect complete eradication of the obstruction. Unfortunately, the cutting current alone did not efficiently control hemorrhage, which often became profuse and uncontrollable. Chiefly for this reason, the use of the resectoscope was practically abandoned.

More recently, Davis has so modified and improved this instrument that the objections have been largely overcome. He devised a transformer, which supplies not only a cutting current, but also a coagulating current. (Fig. 2) By means of an automatic electromagnetic switch, operated by the foot, the coagulating current can be turned on at any time, making immediate coagulation available for controlling hemorrhage with the same electrode employed for cutting. Further, he devised a larger loop electrode with which larger segments of tissue can be taken, thus reducing appreciably the time of operation. (Fig. 3). He also shortened the beak of the instrument to permit its use in those cases of pronounced hypertrophy with a corresponding elongation of the prostatic urethra. In such cases, obstructing tissue must be removed for a distance corresponding to the diameter of the gland as measured from the vesical aspect to the verumontanum. The shortened beak renders this possible. No attempt is made to take the entire gland or all the adenomatous tissue. Sufficient obstructing prostate is removed, however, to provide a well open channel to afford complete relief from the obstructive symptoms.

In cases of this type, the importance and desirability of preparation or preoperative treatment is generally known. On examination, most of these patients have impaired renal function, often of an advanced degree, variable amounts of residual urine with an associated infection, very little cardiovascular reserve, and poor general condition. In former years, before the value of proper preparation was recognized, the mortality rate following prostatectomy was extremely high. One of the most notable advances in the field of urologic surgery, and one on which urologists should pride themselves, is the development of the several factors which have contributed to the reduction of the mortality rate. Chief among these measures of safety is an adequate period of preliminary treatment, the objects of which are: (1) to restore as far as possible normal renal function, as indicated by blood chemistry or phenolsulphonphthalein excretion; (2) to eradicate urinary infection; (3) to establish some degree of immunity to instrumentation in the urinary tract; (4) to build up cardiovascular reserve; and (5) to improve, as far as possible, the general condition of the patient. Other factors of equal importance, which have minimized the risk in these cases, are the use of local anesthesia and the effective control of hemorrhage. When these fundamental principles are observed, the mortality rate of prostatectomy should not exceed five per cent. In isolated series of cases a mortality of less than one per cent has been reported (Hunt and Young). These factors of safety are mentioned because they must be observed just as strictly in transurethral resection. When functional tests indicate approximately normal renal function, when there is little infection, and when no complicating pathologic process is associated,

such as diverticula or vesical calculi, the resection of the prostate may be carried out after a very brief period of preparatory treatment. The need for preliminary suprapubic drainage is relatively infrequent. Occasionally, when renal insufficiency is marked, or when a period of several weeks or months of preoperative treatment must be carried out before a safe resection can be done, suprapubic drainage is preferable to continuous urethral catheter drainage. In two of the cases reported here this plan was followed.

It has been our custom to employ caudal and transsacral anesthesia. A preliminary hypnotic is desirable. We prefer sodium amytal, three to six grains, given rectally about one and one-half hours before operation. If the patient is over-apprehensive or nervous, a hypodermic of morphine also may be indicated.

The time of the operation varies in direct proportion to the size of the gland. When the gland is small and the obstruction is of the median lobe or median bar type, only a few minutes are required to resect the obstructing tissue and control the bleeding by coagulation On the other hand, when the gland is large and hypertrophy of the lateral lobes is great, much more tissue must be resected in order completely to relieve the obstruction and two to three hours may be necessary for the operation.

The tendency to hemorrhage is pronounced in cases in which the gland is large, and a longer time is required for its control. Meticulous care is essential in this part of the operation. Each bleeding point must be found and sealed by the coagulation current to avoid the annoying accumulation of clots, with resulting catheter obstruction following operation. When this has been accomplished, the irrigating fluid should return perfectly clear. In our experience, there has been no difficulty whatever with postoperative hemorrhage, which may be attributed to the care taken to control bleeding at the time of the operation.

Following resection a variable degree of local edema develops, which of itself may produce temporary obstruction. For this reason, an indwelling urethral catheter is fastened in and left in situ for two or three days. By that time, as a rule, the edema has subsided sufficiently to permit its removal. Then thin coagulum over the resected surface undergoes liquefaction necrosis, softens and separates by the tenth or twelfth day, leaving a clean, granulating area. The urine then may become blood tinged from the easily bleeding granulation tissue, and during the period of healing moderate urinary frequency may be expected. At the end of three or four weeks, however, the irritation almost entirely subsides, normal bladder function is restored, and there is no residual urine.

A logical question might be asked: With continued growth of the adenomatous tissue, might not an early recurrence of the obstruction be expected? In actual practice, the obstruction seldom, if ever, recurs. This is due, presumably, to a partial atrophy of the gland which so often follows relief of obstruction and the resulting congestion of the parts. A striking example of this is in the atrophy of the gland commonly observed in the interval be-

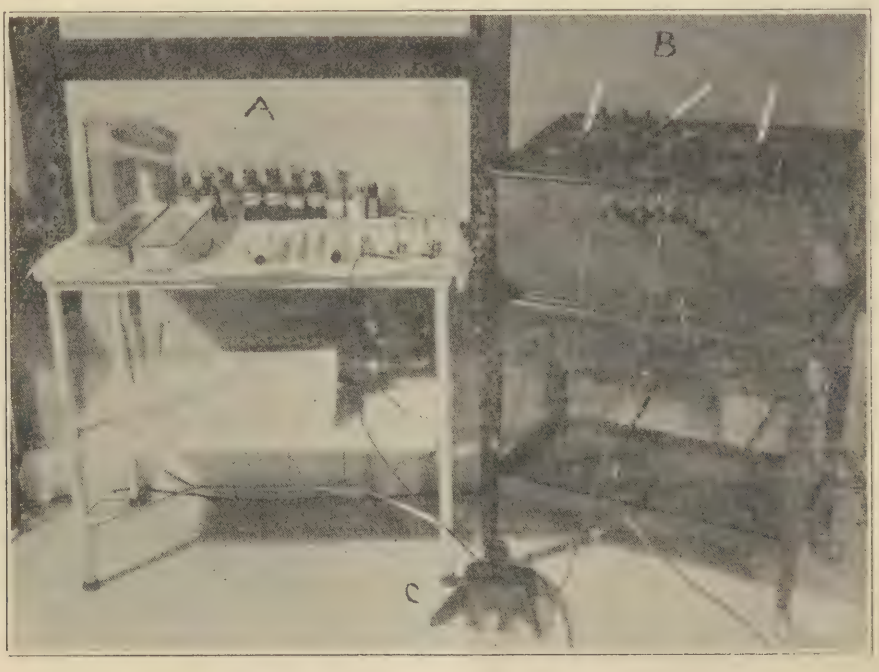

Fig. 2. Equipment employed in transurethral prostatic resection. (A) Table with sterile instruments. (B) Transformer which supplies the cutting and coagulating currents operated by foot switch, (C).

tween a suprapubic drainage and a second stage prostatectomy. Caulk has noted the same atrophic change following the punch operation, and his observations have been confirmed by Davis, who has noted this phenomenon repeatedly in cases in which the resectoscope was employed.

Davis has used this improved resectoscope in almost four hundred cases of prostatic obstruction, both benign and malignant, without a fatality and with no serious complications. Many of these resections were performed three or four years ago, so that sufficient time has elapsed to indicate the permanency of the beneficial effects. Such amazing results constitute irrefutable evidence of the desirability of relieving these elderly patients by this method, as it carries a negligible risk and encouraging prospects of permanent relief. Further, it must

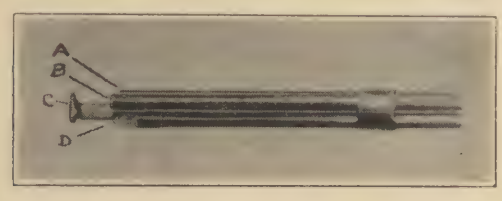

Fig. 3. Working unit of resectoscope. (A) Water conduit. (B) Observation telescope objective. (C) Loop electrode. (D) Incandescent lamp.

be stated that this procedure has passed the experimental stage and bids fair to render almost obsolete the major procedure of prostatectomy.

The following illustrative cases offer striking examples of the manifold advantages of transurethral prostatic resection over the time honored operation of prostatectomy. In each case it will be noted that the functional result was all that could be desired, and that the period of postoperative hospitalization was a matter of but a few days. When compared with the postoperative hospitalization following prostatectomy, which not uncommonly extends over a period of weeks or even months, the economic advantages alone of transurethral prostatic resection are obvious.

Case No. 37243, Mr. W. N. L., aged 82, was referred by Dr. C. R. Senter, of Byhalia, Miss., on account of urinary retention. The patient first experienced difficult micturition three years before. This had slowly and steadily progressed, and a year previously, due to his inability to pass the urine, it became necessary to use a catheter. Difficult urination continued, and six months later catheterization was again required. One week before his examination at the Clinic, acute retention recurred, and it was necessary to pass a catheter once daily. Approximately thirty ounces of urine was usually withdrawn. No urine was passed between catheterizations.

The patient's appetite was poor and he had lost fifteen pounds in weight during the past twelve months. On physical examination, a symmetrically enlarged, firm, smooth prostate, benign in type, was found. The gland was enlarged to a grade III on a basis of IV. The urine contained considerable microscopic blood and a moderate amount of pus. Renal function was normal, as indicated by a non-protein nitrogen of 34.4 mg. The leukocyte count was 13,150, with 74 per cent polymorphonuclear neutrophiles. The patient had a temperature of 101. A roentgen examination of the region of the urinary tract was reported negative. Because of his advanced age, the active urinary infection, and the presence of acute urinary retention, immediate suprapubic drainage under local anesthesia was advised and accepted.

Following the operation, the patient's temperature returned to normal within a few days, the incision about the tube healed by primary intention, and ten days later he was allowed to go home. Prior to his dismissal, a rubber urinal was adjusted to a receptacle for the urine draining from the suprapubic tube. He was advised to return after six weeks for transurethral prostatic resection.

Ten weeks later the patient returned. His general condition had greatly improved. The suprapubic tube had slipped out of the sinus three days before and could not be replaced. He was passing a small amount of urine with considerable effort per urethram; about fifty per cent of the urine output was passed from the suprapubic fistula. The nonprotein nitrogen of the blood was 38.7 mg., and the two-hour phenolsulphonphthalein output, divided into thirty minute periods, was as follows: (1) 14 per cent, (2) 34 per cent, (3) 18 per cent, (4) 7 per cent; total 73 per cent. An in-dwelling urethral catheter was fastened in place and the bladder was irrigated twice daily for three days. Following this treatment, the urine was practically clear.

Under caudal and transsacral anesthesia, a transurethral prostatic resection was performed at The Polyclinic. A grade III adenomatous hypertrophy of the lateral lobes and a small enlargement of the median lobe (grade I) were found. The median lobe was removed, then the left lateral lobe, and, finally, the right latera' lobe were resected as far as the verumontanum. The gland was very vascular and bled easily as the resection progressed, but all bleeding points were effectively controlled by the coagulation current. Approximately twelve grams of prostatic tissue was removed, (Fig. 4) and at the completion of the operation the channel at the vesical neck was wide open. A catheter was left in and the patient returned to the Baptist Memorial Hospital.

The postoperative reaction was light: the highest temperature, on the second day, was 100. The urine remained clear and three days following operation the catheter was removed. A measured amount of fluid injected into the bladder was passed without difficulty and with normal control. Five days following operation the patient was discharged from the hospital. One week later a letter from his home physician

reported that he was in excellent condition, was up and about his farm, and had no urinary complaint except the necessity of passing the urine about every two hours, as the resected area had not yet had time to heal.

Case No. 37509, Mr. W. W. A., aged 72, was referred by Dr. N. G. Gholson, of Holly Springs, Miss. The patient complained of difficult urination, which he first noticed about ten years before. For a year or more the difficulty had been very pronounced and was associated with unusual frequency, both day and night, and the passage of small amounts of urine. He gave no history of acute retention and the use of a catheter had never been necessary.

Fig. 4. Segments of prostatic tissue removed in case No. 37243.

Examination revealed a marked symmetrical enlargement of the prostate, firm in consistency and smooth in outline. There were four ounces of residual urine, which was grossly infected. The renal function was normal, as indicated by a nonprotein nitrogen of 30 mg. and a two-hour phenolsulphonphthalein excretion of 77 per cent, of which 43 per cent was excreted the first half hour and 16 per cent the second. The roentgen examination of the region of the urinary tract was negative. The cystogram was normal except for moderate elevation of the base.

The patient was placed in the hospital for preoperative treatment. A urethral catheter was fastened in place for continuous drainage and medication. He had several severe rigors with high fever, but with appropriate treatment this reaction subsided. After three weeks of preliminary care, his condition was considered satisfactory for resection of the prostate.

Under caudal and transsacral anesthesia at The Polyclinic, a moderately enlarged median lobe and a very pronounced lateral lobe obstruction were corrected by a transurethral prostatic resection. The slight bleeding was well controlled by the coagulating current. A catheter was left in and the patient returned to the Baptist Memorial Hospital.

After operation, the urine was blood tinged for twenty-four hours and was then clear. When the catheter was removed on the third day, it was found that he emptied the bladder completely and with normal control. On the fifth day particles of sloughing tissue appeared in the urine and the patient experienced increased difficulty of urinating, presumably due to the separation of the coagulated tissue in the vesical neck. The urethral catheter was replaced and left in until the tenth day. No further difficulty was experienced after the catheter was finally withdrawn, there was no residual urine, and the control was normal. The patient was discharged from the hospital twelve days following operation.

Case No. 26174, Mr. W. L. J., aged 79, was referred by Dr. N. E. Murphy, of Clarendon, Ark., because of acute urinary retention. The patient had undergone examination at the Polyclinic five years earlier. At that time he suffered from difficult urination and one and one-half ounces of residual urine had been found on cystoscopic examination, due to a moderate median lobe enlargement of the prostate. A punch operation had been advised and refused. The urinary difficulty had steadily and slowly progressed, and for one week before examination catheterization had been necessary two or three times daily. The size of the gland had materially increased since he was first seen. The nonprotein nitrogen of the blood was 46 mg. His urine was grosly infected; the leukocyte count was 14,650 and the polymorphonuclear neutrophiles 74 per cent. A urethral catheter was fastened in for continuous drainage and medication. The following day the patient developed pain in the epigastrium, associated with bloating and eructation of sour material. The pain was referred to the right scapular region. There was marked tenderness beneath the margin of the right costal arch. The leukocyte count had risen to 23,250. On the fourth day, although an ice bag had been kept over the region of the gall bladder, local tenderness was much more pronounced and the leukocyte count had reached 43,600. A diagnosis of empyema of the gall bladder was made and exploration advised.

Under spinal anesthesia a cholecystectomy was done by Dr. Robert L. Mason. The gall bladder was the size of a large pear, distended with purulent material, and there were numerous areas of gangrene varying in diameter from a few millimeters to one centimeter. After removal, drainage was established. At the same time a suprapubic cystostomy was performed because of the prostatic obstruction. The patient made an excellent recovery and was discharged from the hospital on the eighteenth day. A rubber urinal was adjusted to take care of the suprapubic drainage.

Two months later he returned for further consideration of the bladder obstruction. He had gained in a general way, his color was good, and he had no digestive complaint. He was wearing the suprapubic tube with a good deal of local discomfort. The urine was grossly infected. The renal function was normal,

as evidenced by a nonprotein nitrogen on the blood of 30.7 mg. and a two-hour phenolsulphonphthalein excretion of 68 per cent. After a few days of treatment by bladder lavage, the urine was practically clear and he was considered in good condition for a transurethral resection.

The operation was performed at The Polyclinic under caudal and transsacral anesthesia. The suprapubic tube was clamped, in order to permit distention of the bladder. The median lobe was about the size of an English walnut and, in addition, a grade II lateral lobe obstruction was present. The median lobe was removed in its entirety, then both lateral lobes were resected; altogether, about ten grams of prostatic tissue was removed. (Fig. 5). Hemorrhage was slight and effectively controlled by coagulation. A catheter was fastened in the urethra and the patient returned to the Baptist Memorial Hospital.

The following morning the urine was clear and the suprapubic tube was removed. One week later the suprapubic fistula was closed. The catheter was therefore removed. Urination has since been normal, under normal control, and there has been no residual urine. A

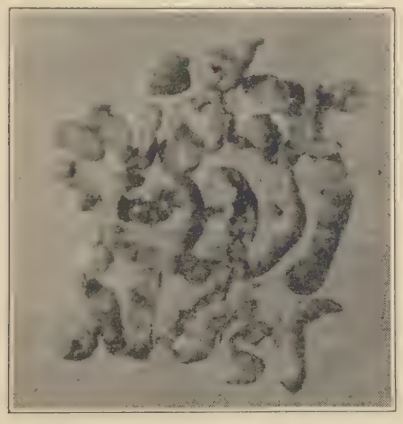

Fig. 5. Prostatic tissue removed in case No. 26174.

free stream is passed and, aside from a moderate frequency, the patient considers himself well. He was discharged from the hospital ten days following operation.

SUMMARY

The instrumental correction of prostatic obstruction may be said to be limited no longer to cases of median bar and median lobe obstruction.

By means of the Stern-Davis resectoscope, all types of prostatic obstruction, both benign and malignant, are amenable to transurethral resection.

When proper preliminary treatment has been carried out, the correction of prostatic obstruction by this method is attended with very slight risk. In a series of nearly four hundred cases operated on by Davis by this means, no fatality nor serious complications have occurred.

As compared with prostatectomy, the functional results are as satisfactory, the period of convalescence is appreciably shortened, the average time being from five to seven days, the hazard is far less, and the beneficial results may be expected to be permanent.

Some Practical Points On The Eye

By Dr. RISCHNER
Memphis, Tenn.

Question of glasses in children. Necessary in myopes and squints. Not often necessary for other symptoms, such as headache, blinking, tiring, etc. These usually depend on other causes and frequently pass off without special attention to the eyes. Children sometimes invent complaints due to a desire to wear glasses.

If glasses are necessary for these conditions they are usually only temporary.

Squint or crossed eyes. Very important to treat such cases soon after the trouble develops. The first thing is glasses, and these can be worn before the end of the second year. Supplementary treatment is possible and often helpful, but as a rule unless the condition is benefitted in a few weeks it will never be benefitted by anything but operation. Tendency to operate early. As early as the fourth or fifth year. Many operations, but the simple "clipping of a muscle" very rarely is sufficient, and several operations are often necessary. A good cosmetic result can usually be secured, but a good functional result is the exception.

MYOPIA—High myopia is usually congenital and occurs in high degree. The acquired form develops in previously normal eyes about the ninth to twelfth years, tends to increase for seven or eight years, and is apparently self limited as to the amount. These cases can be helped by glasses, not only as to vision but as to progress. Difficult problem in girls to get them to wear the glasses. Endocrine influences considered in treatment by adrenalin drops, for which excellent results are claimed. Requires yearly or oftener tests, possibly changes of glasses and refraction if near work. Sometimes advisable to take a child out of school. Difficult to restrict near work because we use the eyes in eating, all indoor life, even sitting talking to people who sit close to us.

GLAUCOMA—Is one of the most important and serious diseases of the eye, and especially because it is so common. The acute form is attended with such violent inflammatory symptoms and sudden loss of vision that it demands attention, and the only thing to say about it is to emphasize the necessity of early treatment. If let run on for ten days or two weeks the damage is permanent. Most cases require operation.

The chronic form is insidious and often overlooked, mistaken for cataract and ascribed to trouble with glasses. Calls for careful examination of all eyes when the need for reading glasses is felt. Most cases show failure of vision only, and often the central vision remains good, so that only expert examination will detect the

trouble at a time when something can be done. Hard to generalize as to treatment as each case has to be considered on its merits. Treatment only arrests and prevents progress, does not restore, so something must be done while vision is still good.

CATARACT—The main thing to say about cataract is that not necessary to wait till it is "ripe" and vision is p. l. only. Now considered proper to operate when the visual needs of the individual can no longer be met. Many cases operated when the eye ground can still be seen. If this fact can be made known people with glaucoma will no longer wait till the eye goes out before seeking relief, thinking they have cataract.

While we may say that we have no cure for cataract except operation, it seems something can be done by glasses, hygiene and attention to the general health to arrest the progress or make the individual more comfortable.

SECOND SIGHT—Is the development of nearsightedness in middle aged and elderly people and means beginning cataract. Ability to read without glasses in the sixties, having previously needed them, is no cause for congratulation.

CEREBRAL CONSIDERATIONS — Cushing said that the commonest symptoms of which patients coming to his service at the Peter Bent Bregham hospital complained, was impairment of vision. Since that statement was published we have more often referred patients with optic nerve disturbance to neural surgeons, with rather astonishing results. Many times the eye symptoms are the first symptoms of central nervous troubles such as tumor, multiple sclerosis and other conditions.

MEDICAL CONDITIONS—The same is very often true of Bright's disease and to some extent of arteriosclerosis. Astonishing how many C. V. R. cases have serious visual disturbances. Don't need eye treatment. Some improve. Many do not.

GOITRE—Aside from well known exophthalmos, too extensive surgery with damage to parathyroids often cause tetany and cataract The fact that this is accompanied by a calcium deficiency started investigations on this line as to the cause of cataract, but it has not brought out anything very definite. Certainly the production of calcium deficiency experimentally does not produce cataract, nor do people with cataract show a lowered blood calcium.

These cataracts present no special surgical problem except the youth of some of the patients. They can be successfully operated. Parathyroid feeding and restoring in calcium content in the blood has improved the vision and cleared the eyes of some cases.

A character, like a kettle, once mended, always wants mending.

In conversation, avoid the extremes of forwardness and reserve.—Cato.

Book Review

"Health Horizons" is a book which should not only be in every doctor's general library, but also incorporated in the curriculum of every high school student. This book would be a handsome addition, if not a necessity, to the home library, so practical is it for use from the kitchen to the drawing-room. Compiled by Miss Jean Broadhurst and Miss Marion Lerrigo, it is dedicated to the memory of Miss Emma Dolfinger, whose services to the country in child welfare work and research begun in the educational program in the schools of Louisville, Ky., have become a blessing of such wide scope we could not measure more than its beginning.

From the earliest theories of health and its relation to air, exercise, clothing sanitation, food, heredity and eugenics, many of them quaintly interesting or amusing, the authors trace tersely and accurately chapter by chapter the progress of the human race in recognizing health values. And our enlightenment of today appears very recent, indeed. From anthrax to yellow fever, the mother and teacher, have a reference for prevention and protection against communicable diseases; from asthma to scurvy, they have the causes of the non-communicable ones. Food and nutrition, a most important subject from infancy to maturity, is exploited clearly and well. Statistic of the amazing progress of medicine and science only intensify the value of this so thoroughly compiled little book, whose intrinsic value is enhanced by the utter readableness of its contents and the concise manner with which they are put together. Price $3.00

Mid-South Assembly for February

Dr. John F. Erdmann, New York, N. Y., Surgery; Dr. Harold O. Jones, Chicago, Ill., Gynecology; Dr. Irvin Abel, Louisville, Ky., Gynecology; Dr. John J. Moorhead, New York, N. Y., Surgery; Dr. Chevalier Jackson, Philadelphia, Pa., Laryngology; Dr. Ralph Pemberton, Philadelphia, Pa., Internal Med.; Dr. Paul D. White, Boston, Mass., Internal Med.; Dr. Ross McPherson, New York, N. Y., Obstetrics; Dr. Sanford Gifford, Chicago, Ill., Ophthalmology; Dr. J. C. Litzenberg, Minneapolis, Minn., Obstetrics; Dr. H. R. M. Landis, Philadelphia, Pa., Internal Med.; Dr. William R. Cubbins, Chicago, Illinois, Surgery; Dr. Vilray P. Blair, St. Louis, Mo., Plastic Surgery; Dr. Harry A. Fowler, Washington, D. C., Urology; Dr. Wilburt Davidson, Durham, N. C., Pediatrics; Dr. Chas. L. Scudder, Boston, Mass., (Fractures), Surgery; Dr. Kenneth M. Lynch, Charleston, S. C., Internal Med.; Dr. A. M. Barrett, Ann Arbor, Mich., Psychiatry; Dr. F. T. Lord, Boston, Mass., Internal Med.; Dr. Chas. A. Elliott, Chicago, Ill., Internal Med.; Dr. Martin H. Fischer, Cincinnati, Ohio, Internal Med.; Dr. Morris H. Fishbein, Chicago, Ill., After Dinner; Drs. Lord and Fischer will speak twice each.

This is to give you an idea in advance of what you have in store for you at the Mid-South Post Graduate Assembly which will meet in February at the Peabody Hotel in Memphis. There is no other medical association like it. Prepare and make ready to go. It will hold for four days. The Shelby County Medical Society is to entertain with a stag supper the first night. Fishbein is the after dinner speaker. This is enough said.

MEDICAL ORGANIZATIONS OLD AND NEW

The editor of the Journal of the American Medical Association' under the editorial caption "Medical Organizations Old and New" Page 932, Vol. 97, No. 13, September 26, 1931, takes occasion to criticise the existence of any and all medical organizations, old or new not under the direct control of the American Medical Association.

As the personnel of practically every medical organization is composed of members of the American Medical Association, and as practically every ethical medical man in the country is a member of some independent medical society, the editorial impresses one that it is the opinion of just one man.

The American Medical Association has done much to strengthen the position of general medicine throughout the country. That it could not represent general medicine and special medicine at the same time is amply proved by the existence of the American College of Surgeons, the American College of Physicians, the American Medical Editors' and Authors' Association had hundreds of other medical societies and associations devoting themselves to specialties and local conditions.

While, on the basis of national economy, the editor of the Journal of the American Medical Association advises physicians "to well consider whether or not money spent in supporting various organizations is providing adequate return" and in criticising all independent organizations, he makes statements relative to the American Medical Editors' and Authors' Association, that to be kind to him, are more critical than correct.

He states that the "Association has been appealing to physicians throughout the country to take membership." The Association has never issued a single invitation to anyone to become a member. As it has done in the past, it takes this present opportunity to extend to any contributor to medical knowledge, an invitation to make application for membership, and in doing so, to submit a list of his books or contributions.

That the Association has been selective and discriminating in electing applicants to membership may be appreciated when one considers that out of the thousands of medical contributors, less than fifteen per cent have been elected. The roster speaks for itself.

The editor of the Journal of the American Medical Association implies that the American Medical Editors' and Authors' Association is a new organization. For his information, the Association began as the American Medical Editors' Association in 1869, and was founded by Dr. Nathan Davis, father of the American Medical Association. Following Dr. Nathan Davis in the office of president of the Association were such men as Theophilus Parvin, Horatio Wood, Henry O. Marcy, George M. Gould, Hobart Armory Hare, Charles E. de M. Sajous, Henry Waldo Coe, James Evelyn Pilcher, Walter Wyman, Thomas L. Stedman, Edgar A. Vander Veer, George M. Piersol, George W. Kosmak, Seale Harris and others whose names stand for honor, accomplishment and undying fame.

The editor of the Journal of the American Medical Association criticises the "Medical Mentor" as a periodical largely devoted to lucubrations on literary topics, et cetera. In this connection one can only regret that the editor did not first consult a standard dictionary before he used the word lucubrations if, as it evidently was, his intention to criticise.

One word more may be said in answer. The editor of the Journal of the American Medical Association in criticising independent medical organizations, sounds a word of warning when he says "members will always do well, however, to inform themselves as to the purposes for which money is collected, the manner of its expenditure, et cetera. This word of warning is good and it is timely—and may be commended not only for independent medical organizations, but for City, County, State and National organizations.—Medical Mentor.

The American Medical Association is all right, fine enough, but hundreds of important subjects of interest to the profession go untouched by it. The Mid-South Medical Assembly is the best four day meeting in the United States. We did not ask the A. M. A. anything about it. We would not take one single honor from the A. M. A. nor the most brilliant editor, but there is plenty of room for the Medical Mentor. It has a fine work to perform.

Ambition is like electricity; useful when properly controlled, dangerous when uncontrolled.

Bad memory has its root in bad attention.

Reading maketh a full man, conference a ready man, and writing an exact man.—Bacon.

Only dead men never change their minds.

On earth there is nothing great but man;
In man there is nothing great but mind.
—William Hamilton.

"Waiter."
"Yes, Sir."
"What's this?"
"It's bean soup, sir."
"I don't care what is has been; the question is, what is it now?"

NEVER BEEN TRIED TWICE

She: "Why are you looking so thoughtful, my dear?"

He: "I was wondering how Jonah got away with it when his wife asked where he had been away from home all that time, and he told her a whale had swallowed him."—John N. Tillman.

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THE MISSISSIPPI DOCTOR

VOL. 9. BOONEVILLE, MISSISSIPPI, DECEMBER, 1931 NO. 6

"Therefore all things whatsoever ye would
that men should do unto you, do ye
even so to them."

Matt. 7:12.

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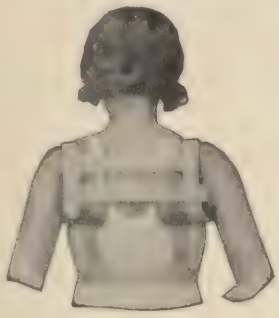

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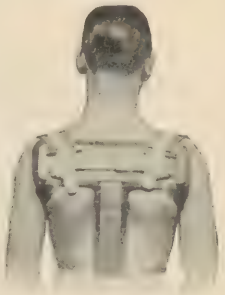

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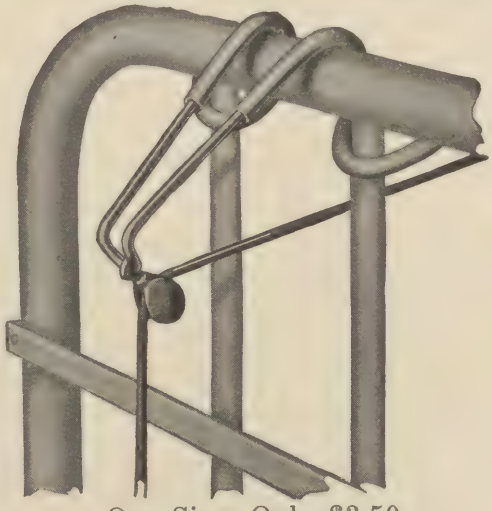

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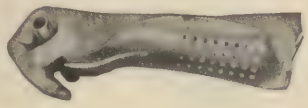

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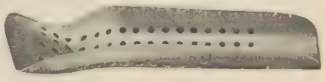

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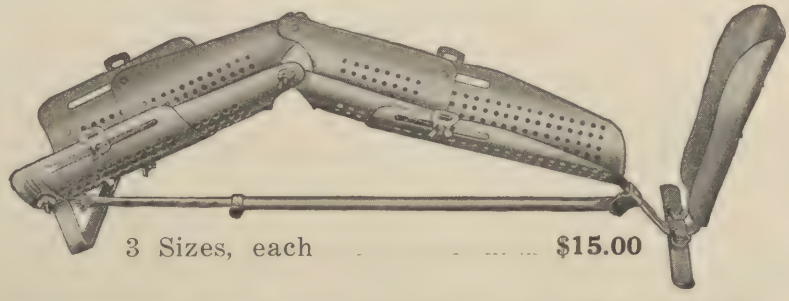

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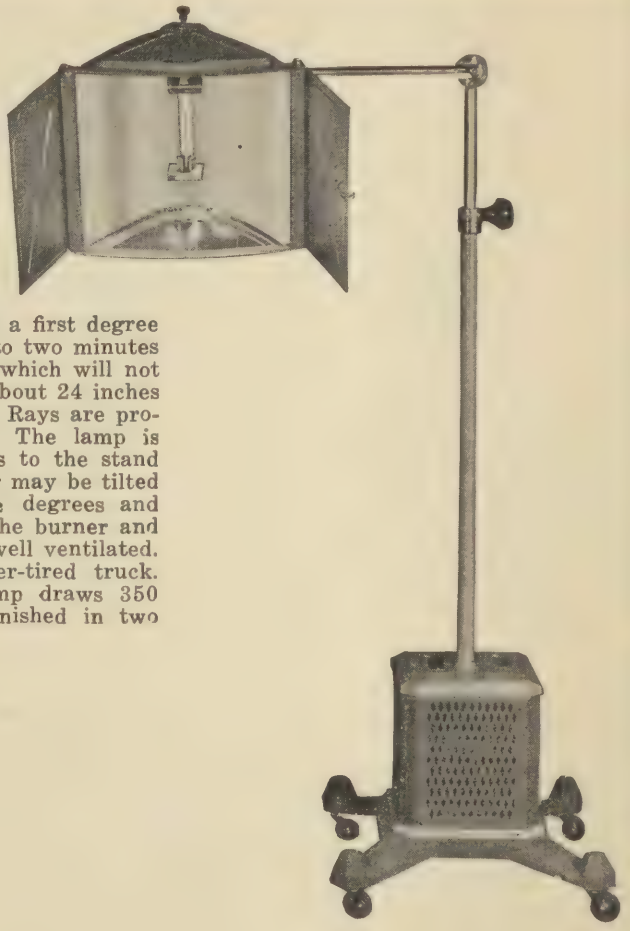

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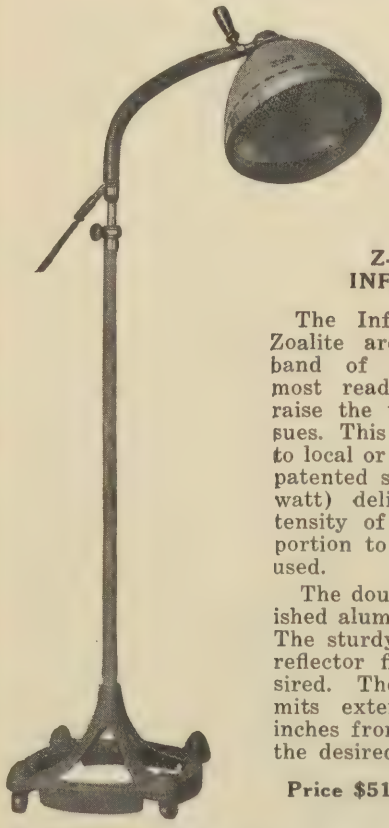

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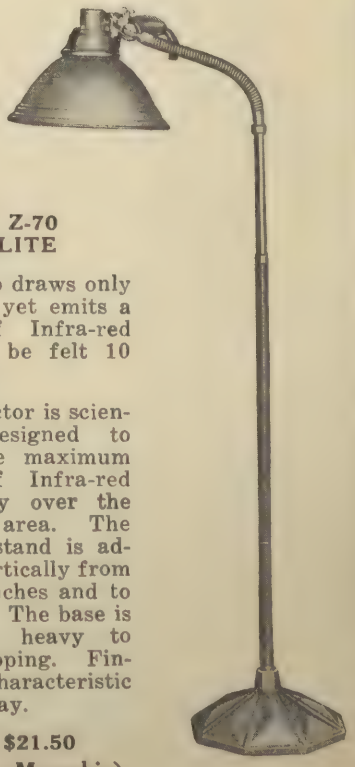

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THE MISSISSIPPI DOCTOR

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—AND—
NORTH MISSISSIPPI 6-COUNTY MEDICAL SOCIETY

W. H. ANDERSON, M. D., Editor and Manager

Entered as second-class matter, January 18, 1926, at the post-office at Booneville, Miss., under the Act of March 3, 1879.

You will read with interest and profit the paper by Dr. A. Street of Vicksburg on Peptic Ulcer. Dr. Street always gives you something worthwhile. He gives you the latest and the best on the subject. We are interested in the Street Bros. They had "their origin" in Northeast Mississippi.

The Southern Medical Association was quite a success considering the "times." New Orleans entertained most cordially as usual. Dr. Felix J. Underwood presided with grace and efficiency and his address was most able. The next meeting goes to Birmingham. This was a fine selection. Birmingham is a fine city. It is full of the spirit of Drs. Harris and Dabney and Mr. Lorenz. They will make the meeting a mighty big success. No doubt about that.

Why not send your friend The Mississippi Doctor for a Xmas gift, one fifty a year for single copy, in clubs of five one dollar. It is the journal with a mission. It publishes very select papers.

It would be a great step forward for medical efficiency and financially also, if the medical profession would invest in office supplies and equipment instead of taking so many chances on every get-rich-quick proposition that comes along.

We want to congratulate Tupelo and Dr. Acker on the fine program presented at the December meeting. It is fine to have men like Drs. Haggard and Collier. Dr. Haggard has been president of the American Medical Association. He is a matchless orator, is well versed in medicine and surgery and is a most magnetic personality.

Keep in mind the Mid-South Medical Assembly in February. It meets at the Peabody Hotel. It gives you more for less money and in less time than any other yet organized. Attending is believing. Go and be convinced.

We are glad to publish a paper by Dr. S. C. Barrow of Shreveport, La. President of the State Association on "Medical Economics"., at the request of some of our subscribers in that commonwealth. It is very interesting and offers food for thought. It deals with state medicine and related problems. Some of the doctor's statements sound a bit strong, yet they have the ring of veracity. Where charity hospitals abound it is pretty sure that many will receive aid that do not really deserve it. On the other hand in medical school centers like New Orleans, Public health departments over step some times. Papers like Dr. Barrow's help us to define the lines more definitely and stay within them. We appreciate his paper. You will enjoy it.

You will read with interest the paper in this issue by Dr. Felix J. Underwood on "Our Medical Problems". He offers as a prophylatic to "state medicine", conservative public health work. He backs this statement up with mighty good reason. This is a paper that you should read and study and consider well. It rests with the medical profession as to whether we will have state medicine. We must give the people such good service that there will be no demand for it. The profession and public health should march hand in hand. They will when they understand. The profession must broaden and extend its service to the public. It must invest in Clinics and hospitals and must do more preventive practice. It is not within the realm of any public health department to do all the preventive work in medicine and surgery. You should file Dr. Underword's paper away for future reference. It is ably written and gives you much valuable information.

A balanced financial system will be the first order of the day for the new legislature. A tax system that will be certain to bring in enough taxes to operate our government and to press as lightly as possible on all and to be as just as can be made to each one who enjoys the protection of our government, is the question.

The removal of our colleges from the "spoils system" as nearly as possible, hard surfaced roads for the main trunk lines, and public schools are the big problems before our "new law makers." Our public health department should be operated as economically as possible, but it should not be crippled if it can possibly be avoided. It will not be good economy. The question of charity funds for the small hospitals of the state will be one of the most important pieces of legislation to be enacted. The small hospital was left in the cold the last four years. The man out at the cross roads and down by the mill who has paid taxes all these years was not considered when he was sick. The hope of this nation, medically speaking, is the well ordered clinic and the small hospital. Our state charity hospitals have no doubt served well in their day, but they are not reaching the people, just a few near by. It is not practical to carry patients two hundred miles to a charity hospital, not even a hundred. We are not making any fight on the state owned hospitals. But we believe that the medical profession, the churches and philanthropy should build and equip the hospitals and that the state should pay for the actual charity that comes to them. We do not believe in encouraging charity. We do not believe in state medicine. The community hospital will help to keep us away from state medicine. It will multiply the efficiency of the medical profession. It will be our greatest means in bringing about an equal distribution of physicians and surgeons. It will bring modern medical service to the people, to the masses, rather than carry them to it. For the state to pay for the charity in the small hospital without investing in hospitals will be a nice piece of economy and at the same time it will do justice to the country folks who have paid taxes all these years and who have not had what was coming to them. A distribution of funds to the small hospital is good economy for the state and good economy for the people. Under this system the entire state can be quite well taken care of for the amount that is now expended on the five state charity hospitals,and it will do away with a multitude of politics. Every man will have his own physician at home, or very near home. If we can keep our splendid state charity hospitals and help the small ones over the state all good and well. Charity needs to be decreased. The distribution to the small hospitals will help to do this. But just a few big charity hospitals over the state will not serve the people now. We have out grown that day. The people up on Yellow Rabbit and down on Vinegar Bend must be considered. Justice must be done. Fairness must be meted out. Economy must be practised. Modern medicine and surgery, preventive and curative, must be delivered to the masses. Where education has been carried, modern medicine can go. More medical service for less money is what a distribution of charity funds to the small hospitals will mean.—The Booneville Independent.

Financial Statement

Financial Statement of The Northeast Mississippi 13 County Medical Society as of Dec. 4, 1931.

Receipts 145 members	$870.00
Refund from defunct Commercial Banking & Trust Company	39.20
Total Receipts 1931	$909.20
Expenditures—	
T. M. Dye State Secretary 145 members	$580.00
Mississippi Doctor 145 subscriptions	145.00
Stationery	50.18
Telegrams and telephone calls	7.12
Stenographic work	5.00
Refund for over paid dues Dr. Hamrick	1.00
Printing programs for the year, with the exception of December meeting	58.85
Total expenditures	$847.15
Balance in bank as of Dec. 4, 1931	$62.05

A doctor was called in to attend an ailing baby.

"You'll have to give him a dose of castor oil," said the medical man to the child's mother.

The mother, one of the ultra-modern type, had expected the prescription to take the form of a violet-ray bath or something like that.

"But, doctor," she said, "castor oil! Castor oil is such an old-fashioned remedy."

The doctor nodded in agreement.

"Babies, madam," he replied, "are old-fashioned things."

Peptic Ulcer*

BY A. STREET M.D.
Vicksburg, Miss.

When mentioning peptic ulcer we think of ulcer located in the duodenum or stomach. However, in a few cases peptic ulcer may and does occur at other points in the gastro-intestinal tract, notably in the lower oesophagus and in the anomaly of the small gut known as Meckel's diverticulum. When such an ulcer occurs at these unusual sites it is probably associated with the presence of areas of ectopically placed gastric mucosa which give rise to acid secretion and maintains the ulceration. These ulcers may give rise to puzzling symptoms, may bleed freely and may perforate. They do not occur often, but it is well to remember that they do occur, especially when dealing with cases of unexplained gastro-intestinal tract hemorrhage.

The incidence of duodenal and gastric ulcer is high. It is conservatively estimated from autopsy and clinical information that 10 per cent of the population of the United States have active or healed ulcers.

The cause is not definitely known. There is strong evidence that some of the following factors have a causative relation:

1. The erosive action of the acid gastric juice.

2. Interference with the normal duodenal reflux, depriving the mucosa of the pyloric region of the protective action of the alkaline duodenal content. Pylorospasm could act in this way.

3. Lowered resistance of areas of mucosa from interference with blood supply. This could result from embolism or thrombosis of small vessels, from ischaemic pressure of muscle spasm, and from spasm or endarteritis.

4. Trophic disturbance, originating from disorders of the vagus or sympathetic nerves.

5. Infection by pathogenic micro-organisms, either local infection or metastatic from focal infection in other parts of the body.

From a practical viewpoint I feel that the most important of these causative factors are the erosive action of the acid gastric content, muscle spasm, and infection.

Consideration of erosion of gastric content brings up the question of variations in composition of gastric juice caused by emotional, psychic, glandular, and dietary factors. Also there may be abnormal variations in the composition and amount of alkaline duodenal content. We know that gastric and duodenal ulcer are unusual in cases of achylia, and that high acid values are common when ulcer is present. Mann and Williamson and later other workers have produced ulcers in dogs exactly like those seen in men. They have produced ulcers that show characteristic chronicity, not usually present in other experimentally produced ulcers. The method is as follows: The animal's stomach is divided at the pylorus, and the duodenal stump closed. The jejunum is then divided close to the duodeno-jejunal junction and the proximal end anastomosed to the ileum. The distal end of the stomach is then anastomosed to the distal end of the jejunum. Thus the stomach and jejunum are entirely deprived of contact with duodenal contents. Nearly 100 per cent of dogs so treated developed typical ulcers and some of them died of hemorrhage or perforation. Then to test the effect of exposing these ulcers to the duodenal fluid, the abdomens of some of the dogs were reopened, the ulcers observed, the operation was taken down and normal anatomy re-established. Later examination showed the ulcers healed. This work seems to prove beyond doubt that erosive action of gastric puice which is not properly mixed with duodenal content is a factor in the cause of ulcer. Ulcers have been produced in animals by section of the vagus nerve, destruction of the celiac ganglion, or destruction of the splanchnic nerves. Also injections into the blood stream of powdered substances intended to produce sterile emboli have successfully produced ulcer. Experimental ulcers have been produced by injecting streptococci, particularly of certain strains, into the blood stream, as was shown by Rosenow and others. Ulcers so produced are not so typical as the ulcers produced by Mann. Saunders and his coworkers have recently presented strong evidence regarding infection as a causative factor of ulcer. They have consistently obtained a particular strain of streptococcus from all of their specimens of resected gastric and duodenal ulcers, and have identified the organism by cultural and agglutination methods. It is interesting to note that this organism would not grow in media containing small amounts of bile.

Bacteria are suspected of initiating ulcer in two ways: 1. By producing embolism or thrombosis of slender blood vessels. 2. By selective action of bacteria or bacterial toxins on the involved tissue.

Judd calls attention to two types of pathology observed in patients who present symptoms of duodenal ulcer: First, those who have localized ulcer, with destruction of one or more layers of the duodenal wall. Second, those with duodenitis, an extensive surface inflammation without destruction of the mucosa. Cases of the duodenitis type will usually respond to medical treatment. Gastritis, involving mostly the pyloric antrum, has also been observed (Konjetnrey, Orator, Kalima) at the time of both primary and secondary operations for ulcer.

Peptic ulcers are most often located near the pylorus, much more often in the duodenum than in the stomach, and usually in the first portion

*Read before the joint meeting of the North Mississippi Medical Society and the Northeast Mississippi Thirteen County Medical Society, University, Mississippi, October 29, 1931.

of the duodenum which is most exposed to the acid gastric content. The lesion may be single or multiple. Ulcer apparently begins as a superficial lesion of the mucosa, the simple acute ulcer. If it does not heal spontaneously or by treatment certain complications will probably develop. These are:

1. Cicatrization, with deformity and varying degrees of obstruction.
2. Hemorrhage.
3. Perforation.
4. There is a possibility of malignant change developing in gastric ulcer, a change which is not likely in ulcer of the duodenum.

Ulcer occurs more often in men than in women. The symptoms have seasonal exacerbations. The characteristic symptoms are usually present. However, they are not always easy to gather from the patient's story. This was first impressed on me by finding ulcer in patients by roentgen ray examination or by laparotomy in whom the history had not suggested the presence of ulcer. Then on going back and cross examining the patient I have almost invariably found that suggestive symptoms were present. Hunger pain, or abdominal distress, usually epigastric, coming on about two to four hours after meals, relieved entirely or partially by food or alkali, and with periods of remission and exacerbation should always cause one to suspect duodenal or stomach pathology. The complications and coincident disease modify the story. As obstruction develops, vomiting and loss of weight become prominent symptoms. If a large hemorrhage takes place, vomiting of blood or tar stools, pallor, weakness, and possibly fainting may occur. Hematemesis is more likely in gastric ulcer and melena from duodenal ulcer. Acute perforation into the peritoneal cavity results in the well known picture. There is abrupt onset of violent abdominal pain. The patient shows evidence of shock. The pulse is usually rapid, but not always. The abdomen shows boardy rigidity. Gas may be evident above the liver as absent liver dullness or by roentgen ray examination. The temperature at first is normal or subnormal. Later the temperature rises and the leukocyte count becomes elevated. All perforations are not of this type. Some are small, the so called pin point type, and give rise to milder symptoms, which may subside in a few hours if the perforation becomes sealed off by fibrinous exudate and adhesions. A duodenal ulcer may perforate posteriorly and retroperitoneally, giving rise to symptoms suggesting perirenal infection.

In arriving at proper diagnosis of gastric and duodenal pathology the physician who takes thorough histories, does careful physical examinations, who uses the stomach tube and gastric analysis, who obtains competent roentgen ray service along with the indicated routine laboratory procedures, including stool examinations, will almost always make the proper diagnosis. A purely exploratory operation is occasionally necessary. I would like to emphasize a few diagnostic points. The most important feature of ulcer pain is its rhythm. The classic rhythm of duodenal ulcer pain is: Food, comfort, pain. That is the pain is relieved by food, recurs in about two to four hours, and lasts until the next meal when it is again relieved. It is stated by some that the above is the rhythm of duodenal ulcer and that the rhythm of gastric ulcer is: Food, comfort, pain, comfort. This would mean that the hunger pain relieves itself before the time of the next meal. For my part I will accept hunger pain relieved by food or alkali as indicative of gastric or duodenal pathology, depending on roentgen ray and other observations to locate it. There are some parapyloric lesions in which the radiologist cannot say on which side of the pylorus the location is.

Gastric analysis is important. We formerly used the Ewald meal extracted in one hour. Recently we have changed to a meal consisting of eight arrow root biscuit and 250 cc of water. The duodenal tube is placed in the stomach before giving the meal and the fasting content obtained. The meal is them given and fractional analysis done, making estimations every 15 minutes for two hours. A rapid rise in the free hydrochloric, or a primary rise and marked secondary rise to high levels is commonly noted in ulcer. It is our experience that the normal range of free hydrochloric acid is from 20 to 40 with the average about 30. The total acid in normal cases runs from about 40 to 80. The finding of blood in gastric content and in the stool is suggestive. We have not found the presence of lactic acid consistently associated with organic pathology. The amount of gastric content found in the fasting stomach gives quantitative information regarding stasis.

We have observed some ulcer cases with low gastric acidity (but not with fract analysis).

The treatment will vary according to the type of pathology present and the type and condition of the patient, his temperament and amount of suffering. The location of the ulcer makes a difference. Gastric ulcer is a more serious disease than duodenal ulcer, and has shown less satisfactory results and a higher mortality with either medical or surgical treatment. Malignancy enters the gastric ulcer problem from two angles, first, because it is not always possible to say for certain whether a lesion is malignancy or ulcer, and second the possibility of development of malignant change in an ulcer. Gastric ulcer probably does not undergo malignant change so often as was formerly thought. Hurst estimates that twenty per cent of gastric cancers develop on the sites of ulcers. Without question the treatment of simple uncomplicated ulcers of the duodenum and small early ulcers of the stomach is medical. Cases with urgent symptoms should be confined to bed, but mild cases may be ambulatory. They should recline one-half to one hour after meals, especially after the noon meal. Ulcer cases do not tolerate concentrated sweets at all

well. Irritating foods, mustard, pepper, tabasco, and acids should be avoided. Alcohol should be avoided, but it is my experience that distilled liquors are tolerated better than wines or beer. Nuts are poorly tolerated. As meat extracts stimulate acid secretion and contain nothing to neutralize it, they are only harmful. Food rich in protein does neutralize acid and is most desirable. Therefore, milk and finely divided meat are important in the diet. Fat is bland and stimulates the flow of alkaline duodenal fluids, therefore, the advantage of cream and butter. Starches are well tolerated and so the ration can be well balanced. Vitamines are important and help maintain resistance. Rest, proper diet, administration of alkali between meals, and eradication of various foci of infection constitute the medical treatment of an uncomplicated case. Vaccine therapy or nonspecific protein therapy may be added.

On any medical treatment some cases will apparently recover. Many cases will continue to have recurrences. Some will perforate, have hemorrhages, or develop obstruction, and still all simple ulcers, especially of the duodenum, should have opportunity to recover on medical treatment.

Surgical treatment is indicated when dealing with complicated ulcer, with a gastric lesion which may be malignant, or with an uncomplicated ulcer which has been treated adequately medically and without relief.

The type of surgical treatment will also depend on the pathology present and the condition of the patient. A patient with advanced nephritis, serious cardio-vascular disease, or with other equally serious conditions besides the ulcer, would, as a matter of course, not be subjected to surgery if avoidable. Young patients, especially of the very nervous type, as a class, do not give the best results with surgical treatment. Patients with marked cicatrization and obstruction afford the ideal indication for gastro-enterostomy. If there is a history of recurrent hemorrhage, the lesion should be resected if possible. Active hemorrhage with acute blood loss should be treated conservatively by transfusion and other medical measures. I know that some European surgeons advise and do operations on patients with acute hemorrhage, but conservative management is generally accepted in America. Acute hemorrhage very rarely results in death. Such patients are bad surgical risks until they recuperate from the blood loss. When they have recovered, examination can be done and proper treatment given, either medical or surgical. Acute intraperitoneal perforation is a most important surgical emergency. Operative mortality is low if operation is done promptly, but high with delayed operation and the longer the delay the greater the mortality. Small or pin point anterior perforations with sealing off, or posterior retroperitoneal perforations are not extreme emergencies, but should be operated upon after taking time for thorough examination.

Opinion as to surgical management of ulcer today is divided into two schools: The first, a large group, includes many of the foremost American and British surgeons, who prefer conservative operations, most often gastroenterostomy, when operating for duodenal ulcer, and who perform partial gastrectomy for gastric ulcer, or for duodenal ulcer in exceptional cases only. The second group includes those surgeons who have adopted partial gastrectomy as the operation of choice for all duodenal and gastric ulcers. Included in this school are Finsterer, Haberer, and Hartman in Europe, and Berg and Lewisohn in America. The resectionist began by reporting remarkably unsatisfactory results following gastroenterostomy. Lewisohn reported that his follow up of gastroenterostomy cases showed the incidence of gastro-jejunal ulcer to be thirty-four per cent. Members of the radically inclined group then adopted partial gastrectomy as ulcer treatment, some on the theory of resecting enough of the acid secreting mucosa to do away with the acid erosion factor of ulcer production, others with the entirely different idea that the resection includes the area of tissue affected by gastritis and its associated infection, which they believe is responsible for both primary and secondary ulcers. The greatest objection to partial gastrectomy for duodenal ulcer is that experience has shown that is does not render the patient immune to marginal ulcer. Belfour and others have reported secondary ulcer in the line of anastomosis following resection operations. Also, judging by reports presented at the recent meeting of the American Surgical Association, results of conservative operations, including gastro-enterostomy, are not so unsatisfactory as claimed by the resectionists. I gather from these reports that the incidence of marginal ulcer following gastro-enterostomy is not over eight per cent, and that well managed conservative surgical treatment is satisfactory in eighty-five to ninety per cent of cases. It is also well to remember that operative mortality from resection is higher than that from gastro-enterostomy and that a patient who develops marginal ulcer following resection is in a much more serious condition than one with the same condition following gastro-enterostomy.

The principal late complications which may follow surgical treatment of ulcer are:

1. Marginal ulcer.
2. Recurrent hemorrhage.
3. Malignant change in a gastric ulcer not removed at operation.

Malignant change can be avoided by the resection of gastric ulcers at the primary operation.

Post operative hemorrhage from ulcer cannot be entirely prevented. However, as already mentioned, when operating for duodenal ulcer upon patients that give a history of hemorrhage, it is wise to resect the ulcer if possible.

Marginal ulcer is a serious complication.

They often perforate, and occasionally perforate into the colon, resulting in gastro-colic fistula. Until recently treatment of such ulcers has been almost entirely surgical. On opening the abdomen of a patient who has had gastro-enterostomy and who has developed marginal ulcer, careful exploration of the abdomen should be done. The original ulcer will usually be found to have healed. In that event the anastomosis can be taken down, resecting the ulcer bearing stoma, and closing the stomach and jejunum, allowing the stomach to again empty itself through the pylorus. If the original ulcer is still active, or the pylorus is not patent, it may be necessary to take down the gastro-enterostomy and do some type of resecting operation. Recently, however, good results in treatment of secondary ulcer have been reported to follow administration of mucin, giving one-half ounce one to two hours after meals. I have recently used mucin and with surprisingly good results. My experience has been with one case of suspected marginal ulcer, one case of recurring post operative-hemorrhage, and in several cases as primary medical treatment of simple ulcer. However, the time of observation has been too short to permit definite judgment as to efficiency.

In conclusion, it is very evident that no treatment of peptic ulcer is perfect. The majority of all cases will do well if proper treatment is used. There is or should be no conflict between advocates of medical and advocates of surgical treatment. Medical men and surgical men should co-operate and suit the treatment to the demands of each individual case. I do not feel that the advocates of radical resection as routine treatment for duodenal ulcer have yet shown that this procedure should be widely adopted. On the other hand I think that when surgery becomes necessary in the management of cases of theod ulcer, conservative surgical measures, used as properly indicated, will give the most satisfactory results. This attitude is supported by some of the ablest American surgeons, and my own experience seems to justify it.

From Tri-County Medical Society

(Copiah, Lincoln, Walthall, Lawrence)

On motion of the secretary pro-tem, W. H. Frizell, the following was adopted: "Resolved, That The Tri-County Medical Society heartily indorses the Community Hospital idea as promulgated by the Mississippi State Medical Association, and that we pledge ourselves to use our influence with the incoming administration to assist in effecting such legislation as in the wisdom of the constituted Committee may suggest to the Legislature at its next sitting."

We are glad to have this good news from the Tri-County Medical Society. This society has some good thinking men, men who will be influential in bringing about this much needed legislation. You are right. You may go forward and fear no evil.

American Medicine—Medical Economics*

BY S. C. BARROW, M.D.
President Louisiana State Medical Society
Shreveport, La.

In bringing to the front the question of Medical Economics, I would have the profession distinctly understand that I have no thought or wish or scheme for devising means and ways of building up the individual doctor's bank account and his financial standard, per se.

The question before the American medical profession today, and more vitally the American public in general, is whether our profession shall continue to operate as a great system, pulsating with a human heart and the individual doctor as the unit, spurred on by personal initiative and ambition, or shall we have, on the other hand, a cold blooded machinery in its stead, with the individual doctor acting merely as a cog in the wheel, attempting to operate as directed by "higher ups," with none of the personal freedom, initiative and stimulus which has characterized our activities in the past.

The former is a principle peculiar to America and has made us great; the latter is foreign to our very nature and confronts us only through the misguided efforts of mis-informed influences.

The history of medicine dates back to the almost forgotten past, into the dark recesses of Egyptian, Hindu, Chinese and Grecian lore; in fact, into the era of mythology when Apollo reigned on Mt. Olympus and sent his mythical son, Aesculapius, to earth to serve the sick and afflicted.

No profession or trade, no avocation or vocation has such ancient history. None of the religions of man date back so far, only the belief in a God paralels, or ante-dates the plans of man for the cure of the sick.

Christ came to earth and cured the spiritually and physically ill; his disciples laid aside their fishing nets and went abroad teaching the doctrines of his faith, with no thought of worldly remuneration. Yet, in this modern day we see, after only 2000 years, his modern disciples and those of other faiths, budgeted for by those communities whom they serve, and no one censures these godly men when we see them move on to larger and more remunerative fields. This is as it should be, though their budgets in most cases are niggardly small.

Tracing the history of all the trades and professions of man, from their earliest inception to this present practical day, we find the imprint of evolution in bold relief scientifically, practically.

Yet in the practice of the Aesculapean Art today, we find still clinging with a death-like grip, certain traditional teachings, influences and impracticalities born to us at the birth of

*Read before the 6th District Medical Society, Jackson, La., October 14, 1931.

history. The practice of medicine has progressed to its present high standard because of its traditions, and we can likewise truthfully say in spite of some of its traditions.

And what is the tradition of medicine which has separated it from the other professions and make it stand out as touched by the hand of God?

The teaching and practice of its members of alleviating pain where ever found, more especially in those unable to provide for themselves. However, through extraneous and selfish influences this tradition has been distorted so that we must serve any and all, with no thought of ones' self, those dependent upon us, or the future of our profession.

I hold it the duty of all men to so conduct themselves and the business in which they are engaged, in such manner that their business may increase in scope and become more useful to society in the future. The practice of medicine is our job and it becomes us to conduct it so, that it shall become more useful to humanity in the future.

I know of no machinery established in this country which will provide ways and means for maintaining the doctor at a high standard of scientific development and equipment, excepting the individual efforts of the doctor himself. Unless these individual efforts produce the ways and means, the individual doctor suffers deterioration, and when he deteriorates, general medicine deteriorates and the public, in the end, must feel the effect.

Modern civilization, if such it can be called, and modern human nature familiar to us all, tends to shift responsibilities to the shoulders of others. Slowly and by degrees, as the complexity of society has increased, pressure from without our ranks and weakness from within, has enabled selfish individuals and organizations to amend our original tradition of free service to the weak to charity service to the strong.

Tradition has been defined as the process by which the teachings of one generation are fixed upon those of the future. Applied to human activities, this practice would result in stasis and no progress. We are living in a changing world and with or without our will, we must change with it.

The audacity with which the individual and the many organized individuals demand the doctors' service regardless, must be met with the calm and dignified request for information as to where lies the responsibility.

There is no sin in the eyes of God or just men in refusing to accept as our responsibility that which rightfully rests upon the shoulders of others. The practice of our profession is our business and our only means of livelihood, and society, however small the community, must come to learn that the care of the indigent sick is just as much its duty as is the care of the indigent hungry. To shift the whole burden to the shoulders of a small group of individuals is manifestly unfair.

The doctor today pays the State of Louisiana a special tax for the privilege of practicing his profession, just as the merchant does for the privilege of selling his goods; he writes his check for the Community Charity fund, he donates to the Salvation Army fund, the Red Cross and other charity demands, just as other good citizens, and yet the community demands that he alone shoulder the burden of providing medical care for the indigent.

Where is the community, or the individual who would be so unfair as to demand of their local merchants that they assume the expense of feeding and clothing the indigent in their midst?

It is not done because distorted tradition has not so directed. When communities learn and act upon the principle that the care of the indigent, whether hungry or sick, is their problem, many of the doctor's problems will be solved and many classed as indigent will get a reclassification.

Coming in from all sides under various guises and disguises, certain activities are lopping off the sources of the doctors income, while we sit idly by playing the "faux pas" and living on distorted tradition.

Many medical men will hold up their hands in horror when the question of finances is mentioned in a medical convention, though their first thought usually is the fee in actual practice; I respect their opinions and grant them their right to act and practice as consistently or inconsistently as they choose, but where is the evil of discussing finances?

Our State and various Parish Associations in their constitution and by-laws provide, among other things, that the material interests of the doctor shall be cared for. The Great Teacher of man discussed money in many of his parables, urged thrift, the practice of economy, and in no instance did he say other than the love of money was an evil.

It is not my purpose to attempt other than to put you on your guard in the matter of the present medical economic trend.

Now the State Board of Health, I am informed by its president, does not desire or intend to enter the practice of curative medicine, but realizes the field of preventive medicine is the activity for which it was created. However, in many instances, our zealous health units are stepping out into active competition with the local profession. I have heard many complaints of this kind and in most instances, it has been shown that members of the local profession, by their assistance, have made these programs possible.

Sixty-two per cent of the hospital beds in the United States today are charity or semi-charity. Seventy-one per cent of the sick today are treated as charity, or semi-charity, and the number is mounting. Tuberculosis Clinics, Children's Clinics, Prenatal Clinics, Venereal Clinics, Outdoor Institutional Clinics, unrestrained, are operated by the doctors on a charity basis in di-

rect competition with themselves, all because of distorted tradition.

The Legislature of our state in years gone by thought it wise to establish two Charity Hospitals for the care of our indigent sick, and we find today the wards of these institutions clogged with men and women well able to pay for their medical care, and taken care of by a staff on a no pay basis, in direct competition with themselves; distorted tradition again at work.

The medical profession of this state should stand shoulder to shoulder and demand that their work in state institutions be paid for. I know of no lawyer who advises these hospital boards, unless he is paid to do it. I know of no experts in other lines who advise without remuneration; but the doctor stands alone as the goat, because of more distorted tradition.

The City of Shreveport, and I use this city only as an example, is using our tax money to provide medical care for people who are well able to pay for medical service. Under the guise of Medical Supervision of School Children, medical service is rendered gratis where parents are well able to pay.

Neither the state, its subdivisions nor municipalities have any right to enter the field of curative medicine, except among its indigent and I hold here that it is the state's duty and in no sense that of the medical profession.

Scattered over our state from one end to the other, are corporations actively engaged in the practice of medicine, yet the State Medical Practice Act provides that only an individual who can stand certain medical examinations shall be permitted to practice medicine.

The Supreme Court of California has recently decided that corporations cannot practice medicine in that state and their corporations and methods of practicing medicine over there, are the same as is going on in Louisiana.

The Supreme Court of Kansas has recently decided that a corporation cannot practice dentistry in that state, and the Supreme Court of Illinois decreed that a corporation cannot practice law in that state. Imagine, if you can, a corporation standing an examination and receiving a certificate to practice medicine.

The Workmen's Compensation Act of this State, drawn ostensibly in the interest of the working man, is operated with an eye for dividends for out of state corporations who grind the doctor down in his charges and usually contract with the cheapest that can be obtained. This lacks good business on their part; it shows poor business and lack of good sense on the part of the doctor.

The insurance companies have no legal right to practice medicine, neither any corporation in our state, as is being done and a test of their right must come sooner or later. I have no knowledge of law and its intricate workings, but there is a broad principle underlying our legal structure, I am informed, which provides that no individual, or concern shall be permitted to do indirectly those things forbidden directly.

Thus we could continue ad infinitum, to cite instances of such nature. We could point to the action of our national government where spineless vote seeking congressmen and senators have yielded to pressure from certain influences in the American Legion and are now providing mdical care to all members of that body, regardless of the fact that their illness has no connection with their service during the war.

We could point to the practice of that wonderful organization, the American Red Cross, which during a devastation, go into a community and supply every need of the unfortunate, except his medical care, and leave the local profession to carry the load alone.

Thus by degrees present conditions, practices, and ideas have become established, and after all is said, what is to be done?

We cannot sit idly by, admitting that the problem is too big to be tackled, as I have heard certain men cringingly admit. The solution is simple, though of course somewhat difficult of application.

Organization and square dealing, one with the other, can accomplish relief from most of our ills.

Our code of ethics as handed down will never be construed by an enlightened public as demanding certain present day practices and impositions. The public must be told and taught the facts. Distorted tradition must be brushed aside and the white flag "No Charge" must float aloft only when emergencies exist and our neighbor has shouldered his portion of the load.

PROGRAM AND INVITATION

You are Cordially Invited to Attend the Regular Quarterly Meeting of the

Northeast Mississippi 13 County Medical Society

to be held in the First Methodist Church at Tupelo, Mississippi
Tuesday, December 15, 1931—7:00 P. M.

—PROGRAM—

1. Meeting Called to Order ..... Dr. C. E. Boyd
2. Invocation ..... Rev. Buhrman
3. "The Acute Abdomen."
   Moving Pictures of Goiter Operation.
   Dr. W. D. Haggard, Nashville, Tenn.
4. "The Vomiting of Pregnancy" .....
   ..... Dr. C. B. McCown
   Discussion Opened by Drs. Eason and Deanes
5. "Surgical Dilemmas" ..... Dr. E. Q. Ewing
   Discussion opened by Drs. Philpot and Ivy
6. President's Address.
7. Business Session.
8. Election of Officers.
9. Banquet, Tupelo Hotel.

African Hunt, with Motion Pictures,
Dr. Casa Collier, Memphis

President, 1932, comes from Lee County

A Few Observations Relative to Our Medical Problems

By FELIX J. UNDERWOOD, M.D.

From an economic standpoint, the health of a nation is of paramount importance to its progress. Every industry, business, or occupation suffers considerable financial loss by ill health of its workers. The health of a nation is of vital concern to its government, good health is an asset of the greatest value, and as an asset which can be attained, it becomes a national responsibility requiring the same care bestowed on it as any other sphere of government work. Practically every government of the present day has its special department and minister dealing with health matters.

From an editorial in the Journal of the American Medical Association, I quote the following:

"A wide variety of views is offered regarding the problems of the medical profession in relation to the public. The adequacy of existing curative and preventive medical services and their effectiveness are being questioned. To these problems the Committee on the Cost of Medical Care is giving careful consideration. It has become imperative to secure facts lest a tragedy of errors supervene. The Commission on Medical Education, organized under the leadership of President Lowell of Harvard University, has already reported an extensive study of the demands and needs for medical service, in part by sampling the demands on general practitioners in communities small enough to give a clear picture of general practice. The preliminary surveys indicated that about seventy-five per cent of the office visits were for minor surgery, upper respiratory infections, and general medical and veneral diseases. About ninety per cent of home visits were for infections of the respiratory tract, general medical and contagious diseases, obstetrics and minor surgery. More than ninety per cent of the illnesses are of types that cannot be controlled on a community basis but are problems of individual patients. Less than ten per cent are diseases against which public health efforts are mainly directed. This fact is an index of the growing efficiency of public health efforts and emphasizes the necessity of treating the patient as well as the disease. The common causes of disabling illnesses and absenteeism correspond closely with eighty per cent of the combined office and home visits of the general practitioner. The dullness of ordinary statistics is lost in some of the discoveries of the Committee on the Cost of Medical Care. They indicate for this country that people are, on the average, disabled by illness at least once annually, men about once a year, women from once to twice, and children more than twice each school year (of 180 days). On the basis of the lowest rate for disabling illness found by the United States Public Health Service, there would be about 130,000,000 cases of disabling illness in the United Statee each year and, if non-disabling illnesses should be added, this figure would be more than doubled. What this may mean is indicated by the conclusion that the 36,000,000 wage earners in the United States lose at least 250,000,000 work days a year and that 24,000,000 school children lose 170,000,000 days each school year. These figures take into account only half of the total population. Numerous surveys have indicated that colds and bronchial conditions, and influenza and grip, are obviously the most serious causes of disability from the standpoint both of frequency and of days lost. On the basis of both the number of cases and the total time lost, digestive diseases and disorders loom large. Diseases of the pharynx, tonsil and larynx—including adenoids, tonsillitis, sore throat and croup—are also of considerable frequency and severity. Then non-venereal diseases of the genito-urniary system and adnexa receive prominence in the list, largely because of the frequency of cases of dysmenorrhea among women and girls; but included are acute and chronic kidney diseases, which each year cause an increasing percentage of the total mortality. It may not be an agreeable reminder, but the medical profession must nevertheless face the warning that in 1928 there were nearly 2,000,000 births in the registration area, many of them followed by complications and a considerable number (a larger proportion than in most civilized countries, by death. On the other hand, the public and particularly a small obstructive group of anti-vaccinationists should properly bear much of the odium of more than 36,000 cases of smallpox reported in a recent year. According to these complications, special estimates place the number of persons in the United States who are mentally defective (feeble-minded, imbeciles, and idiots) at more than 900,000; the number of blind at more than 100,000; the number with major speech defects at 1,000,000 and the number of school children wholly or partly deaf at 3,000,000. This country is by no means oblivious of the great problems here presented. There are in United States more physicians per thousand people than in any other country in the world. Hospital beds and clinics show rapid rates of increase, clinics, having the most spectacular growth of all. Hospitals other than those for nervous and mental diseases contain, on an average, more than 350,000 patients at all times. The total in all hospitals on a single 'average' day is about 700,000. Such striking figures, even with their admitted incompleteness, justify the reminder of Mills of an extent of illness and physical and mental defectiveness in the population which causes an incalculable amount of human suffering and economic loss. Some of these diseases and conditions, Mills adds, rob the nation's people of their vitality and destroy their efficiency; others lead to suden death and the premature cutting of life. This continuance of disease, part of it preventable, indicates a field for the more

widespread and efficient utilization of preventive and curative measures now known."

Much has been said recently about state medicine. It might be well for us to briefly consider and review this subject: State Medicine may be defined as a system whereby all physicians are educated under state control and are salaried by the state. They are to be supported through taxation and receive no direct compensation from their patients. Medical education would be controlled and directed by the state. Practice would be supervised by the state; salaries would be fixed by the state and in proportion to the responsibilities assumed and skill expended. The doctor would be assigned to definite localities, postgraduate courses would be provided and required, vacations would be granted, and there would be pensions for physical disabilities and old age.

We would have none of the overcrowding of the cities and neglect of the rural communities for the doctors would be allocated in accordance with the needs of the communities. There would be none of the nefarious practice of fee splitting because there would be no fees to split. There would be no unnecessary services performed for reasons of financial reward and patients would be referred to the doctor most competent to perform the service rather than to be retained in less competent hands. It is argued that public school education was once more bitterly opposed than is state medicine. And now we have public education and it is costing the taxpayers the tidy sum of not less than two billions of dollars annually. The proponents of state medicine affirm that it is as much the business of the state to prevent and cure diseases as it is to educate our youth; they argue that free education does not pauperize, nor will free medical service. Fifty years ago there was little supervision over medical practice. Now we have state control of licensure. We have industrial commissions. Every community has its health officers, the state provides for the care and instruction of the deaf, the dumb, and the blind; the cripple, the mental defectives, and the victims of venereal and contagious diseases are cared for by the state. The government as well as many private organizations are engaged in educating the public in health problems. We have adjusted ourselves to these obligations and they are generally approved by the medical profession and the public. If it is the duty of the state to provide for these exigencies, why, we are asked, should not the state provide for the acutely ill and injured; for the rich and poor alike? The public schools are open to rich and poor alike; police protection is provided and without class distinction. Why not medicine? Formerly the medical profession was solely concerned with the cure of disease; now the prevention of disease is of most vital concern, and is this not the duty of the state? Traveling clinics, at the expense of the government, are supplying medical services to the widely scattered communities in Alberta. The panel system has long been established in England and is fairly satisfactory to the profession and the public. In Germany, 40,000 doctors are employed by the government and two-thirds of the German population receive medical services and hospital accomodations from the state. The maximum income of a doctor so employed is $50,000. In the Canal Zone there are no private practitioners, no cults, no "patent medicine." All is under government control. Preventive medicine has made the Canal Zone one of the healthiest places in the world. In support of state medicine it is contended that most advances in medical science are made by salaried men and that this will be increasingly so in future years. In support of the contention that state medicine is an economic necessity, it is estimated that there is an annual expenditure in the United States of $700,000,000 for drugs, $2,000,000,000 paid by industries for illness, $6,000,000,000 for lives needlessly lost, $1,200,000,000 for hospital maintenance, $90,000,000 for funerals and only $65,000,000 for public health.

Advocates of state medicine are wont to refer to the Army and Navy Medical Corps as evidences of governmental efficiency in medical affairs. It is contended that, under state medicine, granting that the government would reward the doctors as liberally as it now does the Army and Navy Medical Corps, physicians would be better compensated than they are now in private practice. It is the specialists with larger incomes who would suffer under state control. It is predicted that state medicine would abolish quackery and secret nostrums and that it would foster research in the cause, prevention, and cure of disease, and to a greater degree than is now possible under private direction. The sparsely settled portions of our country are inadequately supplied with doctors and hospitals and it will be the duty of the state to provide facilities for these outlying districts where the private practitioner could not eke out a living. There will be traveling clinics such as are now to be supported and directed by the state of North Carolina for the benefit of rural communities. Medical education is acquired as great expenditures of time, labor, and money. Seven to twelve years of such sacrifices are scarcely justified in the prospect of a salaried job such as state medicine could offer. Admitting that the rank and file of the profession would be better rewarded in state medicine, there would be little incentive to make the necessary preparation for a distinguished career. Take away individuality and you destroy the initiative. State medicine cannot change human nature, though it change human relationships. Independence in medical pratice is an essential to the happiness and prosperity of doctors as is independence in citizenship. There will always be independent practitioners. In the main they will be the most progressive and competent. State medicine will attract the weaker elements of the profession. Those who

are able to pay the price will continue to employ the private practitioner. Those who cannot pay will receive the services of the profession as they now do.

Legitimate all-time public health service in the prevention of all preventable diseases in our deliberate judgment is the best insurance policy against state medicine. The profession should support legitimate public health work for the people but fight with all their might against state medicine, for—with the amazing results which properly conducted public health activities is able to show, with the profession adjusting itself to meet the needs of all classes of citizenship demanding fair treatment from them and while refusing to unduly cater to and pauperize them, yet accord them fair consideration, All Will Be Well.

Disease incidence in Mississippi—cases of and deaths from.

Cases	1920	1930	Deaths	1920	1930
Malaria	118,376	50.477		722	281
Diphtheria	2,225	1,273		282	156
Tuberculosis	4,180	3.067		2.271	1,750
Typhoid Fever	2,614	1,239		342	238
Scarlet Fever	1,610	885		20	16
Smallpox	3,148	312		44	2

It is to the credit of our profession that its members have interested themselves actively in good government, and especially in those functions that have to do with the physical well-being of man and that involve applications of medical art and science both in the prevention and the cure of the diseases which afflict mankind.

There is not a single point at which public health and private medicine cannot march forward in peace and good will. Our profession is traditionally committed to the prevention, as well as the cure, of disease. Out of its early labors arose the first slender shoot of this magnificant tree of health that is beginning to bear good fruit today. From its membership have come our foremost public health leaders. Be it said to the everlasting credit and to the honor of American physicians that they are watering, fertilizing, and protecting this tree of life in the midst of the garden of our united effort against the insects and poison bugs of ignorance, superstition, and of rampant quackery, which establishes so-called health institutes, health homes, advertises so much about your health and often puts it over on a gullible uninformed public and yet knows little or nothing of medicine, either curative or preventive, notwithstanding the fact that they pose as physicians and talk glibly and advertise freely to prevent and cure all diseases which afflict the race. They bitterly oppose the principles and practice of preventive medicine, denouncing immunization and vaccination. They profess not to believe in the germ theory of disease, yet so ignorantly inconsistent are they that most of them tell people that immunization and vaccination cause many diseases, such as syphilis, typhoid fever, meningitis, and within this week I have had otherwise intelligent people call me and tell me what some quack said about it.

Do we need a consistent, persistent program backed up by the physician one hundred per cent for the enlightenment and for the protection of our citizenship in every county, in every community, in every home, and with every individual in our State? Do we? Health education like Christian education is a real job in this day and time when evil forces are presenting a united front. We must stand united in our efforts or we fail miserably.

The most obscure physician gives some portion of his energies to the conservation of health and usually leads his voice in support of public health measures.

The most obscure physician gives some portion of his energies to the conservation of health and usually leads his voice in support of public measures.

Lack of information is a universal fomenter of strife. For the physician disciplined in diagnosis and therapeutics, the private relationship between patients and practitioner circumscribes his horizon. That medicine also fills a public relationship, in which the good of the individual may frequently be submerged by the greater welfare of the group, is outside the compass of his vision. He is unwilling to admit that a mass of information and a technique have grown up within the realm of preventive medicine and sanitation that are generally ignored in our medical schools, yet are just as valid as the subjects regularly taught. The smattering of so-called "hygiene and public health" that was forced on him in student days appears to him to comprise all that is or needs to be known. Every health officer is acquainted with private practitioners who freely admit their ability to fill any public health position with distinction with no previous training. A mind that is permanently closed to new knowledge in other spheres than its own will discount all such new ideas as negligible or subversive of the regular order. Even the physician with a reasonable flexible mental apparatus is often amazingly uninformed of the first principles in preventive medicine and sanitation, a field so closely allied to his own that curosity alone would seem to compel superficial acquaintance. Out of this lack of information grows resentment toward even the simpler routine procedures of common sanitary practice. An attitude is created which evinces itself in unthinking resistance to all that bears the label of public health. Fortunately, this inertia is not often found among physicians.

However, not all of the blame is on one side. The public health worker must share some of it, for he fails many times to make any effort to enlighten the physicians within his field as to his plan and methods. A full explanation, at the outset, would usually convert medical opposition into acquiescense, at least, if not hearty support. His first duty is to educate the doctor, for we are all laymen outside our own specialties. In this, as in every succeeding step of his

program, the utmost tact is essential. Painful memories rise to haunt the health executive who has had under his direction any number of workers. He has seen, more than once, an initially friendly group of medical men turned into enemies of the entire health program through rudeness, arrogance, superciliousness, bad temper, or lack of public health training on the part of a new worker. The medical profession has suffered much at the hands of such as these. Unsound judgment in selecting a project. or offensive methods of promoting it, will also alienate friends.

Of one cause of medical opposition, selfish, mercenary motive, the less said the better. But all experienced health officers have felt its force. The physician of this caliber is so frequently aggressive and "unsuccessful" that he holds an influential position in his community. By underground methods he can defeat an honest, well considered project without revealing his hand. That he fears the specter of diminished business is simply evidence that his selfishness is matched by his ignorance, for the real all-time well trained health officer is a press agent of scientific medicine.

Granting them that there is sometimes divergence of interests between public and private medicine, where there should be convergence; that there is antagonism where there should be accord, it will be profitable to consider its effects. They will manifest themselves in two directions: retardation of sanitary progress in many quarters, and a growing distrust of the medical profession on the part of the public. Enough examples have been given earlier to clarify the first point that lack of medical support, or active opposition, will delay legitimate public health developments. But the effect of this attitude on the lay mind may not be so evident to the private practitioner. To the medical health officer, standing midway between him and the public, a view in both directions is possible. He catches a sense of frustration and of growing exasperation among the laity, that is not revealed to the family doctor so freely. He finds the public demanding more service while his medical colleagues criticize what is already given. He realizes that the public is often more fully sold on the health program than is the profession. His dilemma is sometimes acute. As a public servant, his duty is to do the public's will. Yet, if he accedes, it will bring to light the reactionary tendency of the medical group. He feels himself a Judas among his brethren. If such a crisis arises. as it has repeatedly, the layman develops a distrust of the physicians; he is openly critical of their motives and his resentment is likely to be extreme. Are not the proposals for health insurance partly the result of just such a process? Are they not the grasping of the public after some method whereby the benfits of curative and preventive medicine may be made available to all, and at once, without waiting for the medical profession to arrive at a broader social outlook? This is not the sort of thing that the great body of health workers desires, but is a very natural reaction of enlightened public opinion. "Phantom" this public opinion may sometimes be, but it is a ghost that takes on substance as it gains momentum.

If the discussion so far is a correct interpretation of trends, some solution is sorely needed. Not that we may hope to change human nature, if the fault lies there, but that we may try to bring about more intelligent understanding on both sides and a resultant solidarity now lacking. Beginning with his earliest medical training, the student should be made to see how his subjects are related to public health. In bacteriology he can learn the uses and duties of state and city laboratories, the methods pursued by them and interpretation of their reports. Lecturers on practice of medicine ought to lay more stress on sources and modes of infection, on ordinary control measures, and on the duty of the private physician to protect the community as well as his patient. Courses in pediatrics open the way to the whole field of child hygiene while obstetrics holds the same relationship to prenatal and maternal hygiene. Medical jurisprudence embraces legal aspects of the practitioner's public health functions. And, lastly, the course in preventive medicine, hygiene, and sanitation should be the point at which these strands are woven together; where the embryonic doctor sees the whole public health field and comprehends the fact that he has a prominent and inescapable position in it. Do we have such correlation in our medical courses today? Hardly. Most of the men who are teaching major subjects in the schools are themselves lacking in this vision. Can more be expected of the people when their leaders fail?

The medical practitioner has a real place in the public health field. As a matter of fact, preventive medicine is going to consume an even greater proportion of his time. This does not mean those ordinary things that are expected of every conscientious doctor such as early biologic preparations, efforts to protect the community against the infection of his patient, and occasional help in various clinics for the indigent. These he does now to a greater or less degree. But preventive medicine has taken on a broader meaning in recent years. There has come a realization that humanity can be made healthier, and happier, by the early detection and correction of minor deviations from normal, than by curative measures applied after these conditions have produced gross pathology. "Positive health" is as good a name as any for this new objective. And the family doctor is its prophet. Better than anyone else, he can, if he will, make the next generation more fit than its predecessor. This calls for a personal relationship that no governmental agency can so satisfactorily provide. Opportunity is in the making for the private practitioner to take his own peculiar place in the public health movement. Technical preparation

there must be, exactly as one would fit himself for any other special procedure. A new approach, a new viewpoint, must be acquired. He is dealing with a well man who wants to keep well.

The health officer prepares the way by education and the physician should make ready for the future that lies in that direction. The American Medical Association has repeatedly endorsed this program. Likewise, state and county societies here and there have caught the meaning of it. But until the man in general practice makes it a real part of his everyday business, it will remain only a pleasant topic of conversation. This is the challenge of the sanitarian to the private practitioner.

Wrapped up with these matters that have been touched on are problems of the medical profession far more profound and significant. What does it mean that there is an active demand in some quarters for a kind of state medicine? Why do we see such contemptuous disregard for the fine fruit of scientific medicine, while any new and blatant cult receives enthusiastic welcome? Opposed as these two trends may seem on the surface they arise from a common source; lack of socially minded leadership within the profession. Broadminded, strong, resourceful leaders can point the way and can knit our individualistic membership into a well co-ordinated group for the solution of these difficulties. Without that, we have forced on us a ready-made scheme of social medicine.

In other words, the public wants and demands a complete program of health and healing, of which every individual may have the benefit without undue sacrifice, and it is going to have its way somehow. We have the requisite knowledge and skill. Are we intelligent enough to co-operate in meeting this need with a plan of our own devising?

Book Review

"Health Protection for the Pre-school Child" is one of the White House Conference publications, published by The Century Company, of New York. This most illuminating survey recounts the intensive data from 156 American cities which made up the report before the above conference of the preventive medical and dental service being rendered the children under six years of age—the pre-school child. There were four major preventive measures employed to cover the work that is done for the health of the child; namely, periodic examinations, immunization against diphtheria, vaccination against smallpox, and dental examinations. Charts figure alongside the discussion of the survey, indicating accurately and comprehensively the percentage status of these measures. A median area, or Midway City, struck the balance geographically and economically between the cities compared, as well as between urban and rural statistics. It is a significant fact that in only very few instances did a report exceed the 50 per cent mark in the children reached.

Detailed information is computed and outlined for the use of the organization which undertakes the health protection plan followed by the White House Conference. Explicit directions are laid out for supervisors in the urban and rural work, including the discussions for family interviews and model forms for recording the survey. This book is the replete information of the Conference on the Child Protection division of its work. It is an invaluable addition to your books on the pre-school child.

Price $2.50. The Century Co., N. Y.

"Every time I have an argument with my wife I enter it in a diary."

"Ah, I see. You keep a scrapbook."

Customer—Chicken croquettes, please.

Waiter (calling to kitchen)—Fowl ball!

The above is the graduating class of '31 of the Northeast Mississippi Hospital located at Booneville. As they appear, from left to right, Misses Artie Booth, Ruby Allen, and Pauline Morgan have completed the requirements imposed by the hospital for the degree of Registered Nurse. This month they will take the state board examinations, after which their titles of R. N. will be justly awarded.

Miss Morgan is from Tishomingo, Miss Allen from Dennis, and Miss Booth from Burnsville. Booneville and the home towns from which these young women come are duly proud of the career for service they have undertaken, and congratulate them on the fine manner in which they have equipped themselves.

Dean Mull Explains

OXFORD, Miss., Dec. 6.—Informed that some misunderstanding exists relative to the status of the University of Mississippi medical school since the meeting of the Association of American Medical Colleges in New Orleans Nov. 30 to Dec. 2, Dr. P. L. Mull, dean of the school, tonight issued the following statement:

"The University of Mississippi medical school is still on probation, doing A-grade work, and its sophomore students will be able to transfer to the junior class of other class A schools next year without examination.

"At the executive session of the A. A. M. C. in the Roosevelt Hotel at New Orleans, Tuesday night, Dec. 1, the association unanimously passed resolutions congratulating the faculty of the medical school, the alumni, the State Medical Association, the State Educational Association and all others interested in higher education in the state for their splendid and heroic efforts in the interest of high ideals in education in Mississippi, and continuing the medical school on probation for another year.

"This is all that we asked of the association and meets with the approval of the parties concerned in the welfare of the medical school."

THE OLE MISS GET-TOGETHER MEETING, OCTOBER 22, 1931.

The above is a picture of those who attended the recent get-together meeting at Ole Miss in honor of Dean Mull and President Culley. The background shows the Medical Building at Ole Miss.

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